

Lauren G. Macaluso, MD, FAAP, IBCLC, PC

Date: _____

Last Name: _____ **First Name:** _____

Social Security Number: _____ - _____ - _____ Birthdate: ____/____/____

Marital Status: Married: _____ Single: _____ Divorced: _____ Separated: _____

Address: _____

City, State and Zip Code: _____

Name of Baby: _____

Sex of Baby: Male: _____ Female: _____ **Birthdate of Baby:** ____/____/____

Home Phone: (____) _____ Email: _____@_____

Work Phone: (____) _____

Cell Phone: (____) _____

Occupation/ Date of return: _____

Mother's Insurance Plan:

Plan Name: _____

Policy/ID number: _____

Policy Holder Name: _____

Policy Holder Social Security #: _____

Policy Holder Date of Birth: _____

Baby's Insurance Plan: (IF DIFFERENT FROM MOTHER'S INSURANCE)

Plan Name: _____

Policy/ID number: _____

Policy Holder Name: _____

Policy Holder Social Security #: _____

Policy Holder Date of Birth: _____

Referring Physician/ Hospital: _____

Pediatrician: _____

Address: _____

City, State and Zip Code: _____

Phone: (____) _____ Fax: (____) _____

Ob/ Gyn/ Midwife: _____

Address: _____

City, State and Zip Code: _____

Phone: (____) _____ Fax: (____) _____

Reason for visit:

Please list any current medical problems that you may have:

Surgeries, breast biopsies, lumps, nipple problems:

Medications, including prenatal vitamins, antihistamine, birth control, antibiotics:

Allergies:

Family History:

Please list any medical conditions that your relatives have/had.

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Children: _____

Do you smoke? Yes: ___ No: ___ Have you ever? Yes: ___ No: ___ How many packs per day? _____

Do you drink alcohol? Yes: ___ No: ___ If so, how much and how often? _____

Have you ever used any illicit drugs? Yes: ___ No: ___

Pregnancy History:

of pregnancies: _____ # of living children: _____

Current pregnancy / delivered infant's # of weeks gestation: _____

Normal spontaneous vaginal delivery _____ or c-section _____ (check one)

Any complications (pregnancy or delivery): _____

Mother Review of Systems:

Please put a check mark next to any symptom you have had recently.

1 - General Symptoms:

- Weight changes, unrelated to normal pregnancy
- Bleeding, unrelated to normal postpartum
- Chills
- Recent infection
- Appetite changes
- Fever
- Recent trauma

2 - Nipples:

- Nipple soreness
- Nipple bleeding
- Nipple cracks

3 - Lactation:

Fullness, milk in, if yes when:

- Expressing breastmilk
- Using hand expression
- Using electric breastpump, if yes, which one: _____
- Using manual breastpump, if yes, which one: _____
- If pumping or expressing how frequently: _____
- For how long per session: _____
- General amount of breastmilk expressed per pumping session: _____

4 - Breasts:

- Surgery, if yes, what procedure
 - Implants
 - Lumpectomy
 - Reduction
- Redness
- Warmth
- Pain
- Swelling

Mother Review of Systems Continued:

Please put a check mark next to any symptoms you have had recently.

5 - Head, Eyes, Ears, Mouth, Nose and Throat:

- Vision changes
- Nose bleeding
- Swallowing difficulties
- Ear pain
- Neck pain
- Neck stiffness
- Hearing changes
- Unusual sneezing
- Sore throat
- Facial pain
- Neck swelling

6 - Lungs:

- Cough
- Shortness of breath
- Blood in sputum
- Wheezing

7 - Heart:

- Palpitations
- Chest pain

8 - Abdomen:

- Pain
- Vomiting
- Constipation
- Pale colored stools
- Nausea
- Diarrhea
- Dark or bloody stools
- Flatulence

9 - Genitourinary:

- Pain with urination
- Urinary urgency
- Incontinence
- Urinary frequency
- Dark urine

10 - Bones, Joints, Extremities:

- Joint pain
- Back pain
- Muscle pain
- Joint stiffness
- Muscle cramps

11 - Skin:

- Rash
- Sweatiness
- Itchiness
- Skin lesions
- Bruising

12 - Neurological, Psychiatric:

- Depression
- Memory loss
- Double vision
- Vertigo
- Numbness
- Suicidal ideation
- Disorientation
- Dizziness
- Clumsiness
- Head pain

Baby Review of Systems:

Please put a check mark next to any symptoms baby has had recently.

General Symptoms:

- Crying more than usual
- Sleeping poorly
- Difficult to awaken
- Fever

Head, Eyes, Ears, Mouth, Nose and Throat:

- Tongue tie
- Abnormal palate

Neck:

- Limited motion

Lungs:

- Cough
- Congestion

Heart:

- Murmur

Genitourinary:

- Diaper rash

Musculoskeletal:

- Torticollis
- Developmental dysplasia hip

Abdomen/Gastrointestinal:

- Vomiting
- Diarrhea
- Constipation

Skin:

- Jaundice
- Rash