PATIENT RECORD

DATE:

Family Information: Child's Name: Sex: M/F Date of Birth:

Parent(s) Name:

Home Address: Phone # (H):

Employer: Phone # (W):

Insurance Co. Policy #: Co-Pay:

DRUG ALLERGIES AND IMPORTANT DIAGNOSES

Drug Allergies: Yes: No:

Illness/Injury/Congenital Condition:

FAMILY/MEDICAL HISTORY

Allergies: Receives allergy shots: Drug Allergies:

Asthma: Eczema: Ear Tubes:

Frequent Respiratory Infections: Sinus Infections:

Anemia or Blood Disorder: Diabetes:

Stomach/Intestinal Disorders: Growth problems:

Seizures: High Cholesterol: High Blood Pressure:

Hereditary Problems: Surgical problems:

School Problems: Heart problems:

Emotional or Behavioral Problems: Kidney/bladder disease:

Did mother use tobacco, alcohol, recreational drugs during pregnancy:

Other:

MATERNAL AND NEWBORN HISTORY

PREGNANCY:

Excessive wt. gain: Urinary Tract Infection:

Excessive swelling: Toxemia:

Medications: Illnesses:

Other:

BIRTH: DELIVERY: Vaginal: Caesarean Section:

Was the baby full term or premature: .Weeks Birth weight:

Was the labor difficult or prolonged: Yes: No:

NEWBORN: Breast: Formula:

Feeding problems Multiple formula changes:

Colic Blood in stool:

Recurrent vomiting: Slow weight gain:

Recurrent Diarrhea Jaundice:

Other:

CURRENT MEDICAL HISTORY

Is your child having any medical problems? Yes: No:

Signature: Relationship to patient