

**PATIENT RECORD**

DATE:

**Family Information:** Child's Name:

Sex: M/F

Date of Birth:

Parent(s) Name:

Home Address:

Employer:

Insurance Co.

Phone # (H):

Phone # (W):

Policy #:

Co-Pay:

**DRUG ALLERGIES AND IMPORTANT DIAGNOSES**

Drug Allergies: Yes: No:

Illness/Injury/Congenital Condition:

**FAMILY/MEDICAL HISTORY**

Allergies:

Asthma:

Frequent Respiratory Infections:

Anemia or Blood Disorder:

Stomach/Intestinal Disorders:

Seizures:

Hereditary Problems:

School Problems:

Emotional or Behavioral Problems:

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

Other:

Receives allergy shots:

Eczema:

High Cholesterol:

Drug Allergies:

Ear Tubes:

Sinus Infections:

Diabetes:

Growth problems:

High Blood Pressure:

Surgical problems:

Heart problems:

Kidney/bladder disease:

**MATERNAL AND NEWBORN HISTORY**

**PREGNANCY:**

Excessive wt. gain:

Excessive swelling:

Medications:

Other:

Urinary Tract Infection:

Toxemia:

Illnesses:

**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

Colic

Recurrent vomiting:

Recurrent Diarrhea

Other:

Multiple formula changes:

Blood in stool:

Slow weight gain:

Jaundice:

**CURRENT MEDICAL HISTORY**

Is your child having any medical problems? Yes:

No:

Signature:

Relationship to patient

