PATIENT MEDICAL HISTORY

CHILD'S NAME:____
Last First Middle

DATE OF BIRTH: ______________________________ **SEX:** ☐Male ☐Female

List Any Known Allergies: ____

Birth and Development

Hospital of Birth ______________________________________ O.B. Doctor _____________________________________

Type of Delivery: ☐ Normal ☐ C-Section Birth Weight ______________

☐ Full Term ☐ Premature (If Premature, what was gestational age? _______ weeks)

Please describe any problems at birth ____

Please fill in age when these occurred as it applies to your child:

Rolled Over ____________ Sat up _____________ Walked ________________ 1st Teeth _____________

Potty Trained ___________ Rode Tricycle ____________

Family History

FAMILY MEMBERS	Date of Birth	HEALTH PROBLEMS
Mother ________________________________	___________	_______________________________________
Father ________________________________	___________	_______________________________________
Sibling ________________________________	___________	_______________________________________
Sibling ________________________________	___________	_______________________________________
Sibling ________________________________	___________	_______________________________________

Medical History

Please list any medical problems your child has: ____

Please list any hospitalizations ________________________________ Any surgeries? ___________________________________

Please list all current medicines: ____

Has your child had chicken pox? ☐Yes ☐No Primary drinking water: ☐City or County ☐ Well ☐Bottled

Important: We need a copy of your child's immunization records.