CONYERS PEDIATRICS

PATIENT MEDICAL HISTORY

CHILD'S NAME:_____
Last First Middle

BIRTH DATE: _____ ☐Male ☐Female All 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)

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: _____

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

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