MEDICAL HISTORY

PATIENT INFORMATION

Patient Name_____ Birth Date _____ SSN _____
Name your child wishes to be called _____ Sex ☐F ☐M Age _____
Address _____ Home Phone _____
_____ Child's School _____ Grade_____
Siblings _____

FAMILY INFORMATION

Who referred you to the office?_____
Have any members of your family been seen in our office? _____

Mother's Name:_____ Birth Date _____ SSN _____
Address: _____ Home Phone _____
_____ Cell Phone_____
_____ Employer_____
Email: _____ Employer Phone _____
Father's Name: _____ Birth Date _____ SSN _____
Address: _____ Home Phone _____
_____ Cell Phone_____
_____ Employer_____
Email: _____ Employer Phone _____
Child resides with: ☐ Mother ☐ Father ☐ Both Parents ☐ other _____
Address _____ Home Phone _____
_____ Employer_____
_____ Employer Phone_____

Person responsible for payment on account

_____

Note: If a person is not specified above, the person who brings the child to their initial visit will be listed as the Guarantor on the account. All correspondence will be addressed and mailed to the person listed as the Guarantor. If a family member is already listed in our system we will add the patient to the existing account unless we are instructed otherwise

HEALTH HISTORY

Who is your child's pediatrician/medical doctor? _____Phone_____
Has your child ever been hospitalized? Yes No
If so, give reason._____
Does your child have any allergies to medications or substances? Yes No
If so, please list._____
Does your child have any other allergies? Yes No
Is your child currently taking any medications or substances? Yes No
If so, please list. _____

Does your child have or has your child ever had any of the following?

Rheumatic Fever	Yes	No	Leukemia	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	Heart Murmur	Yes	No	AIDS	Yes	No
Anemia	Yes	No	HIV Positive	Yes	No	Hemophilia	Yes	No
Hepatitis	Yes	No	Asthma	Yes	No	Tuberculosis	Yes	No
Epilepsy	Yes	No	Cleft Lip/Palate	Yes	No	Other Seizures	Yes	No

Please describe any of the above conditions that you have stated "yes" to:

_____
Does your child have any disease, condition or problem not listed?

Genetic Conditions/MTHFR? Yes No

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