CHILDREN'S PHYSICIANS

Patient's Name:_____ Patient's DOB: _____

PAST MEDICAL HISTORY (Please check YES or NO. Write an explanation of YES answers on the line).

Birth Hx: □ Vaginal □ Cesarean □ NICU □ Due Date:_____ □ Birth Wt_____ Complications_____

□ Yes □ No Serious illness or medical condition (asthma, diabetes, ADHD)_____

□ Yes □ No Serious injury or accident_____

□ Yes □ No Surgery_____

□ Yes □ No Hospitalization_____

□ Yes □ No Serious Behavior/Mental Problems/Developmental Delay_____

□ Yes □ No Receiving medical care from a specialist – who?_____

□ Yes □ No Taking medication _____

□ Yes □ No Delayed or missing immunizations_____

□ Yes □ No Recurrent medical problems (ear infection, UTI, strep)_____

□ Yes □ No Allergies (Medication/Food/Environmental)_____

FAMILY MEDICAL HISTORY (Please check all that apply for BIOLOGICAL family members. For siblings, please indicate who: aunt, uncle, cousin, etc.)

	Mother	Father	Brother/Sister	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Mother's Siblings	Father's Siblings
Allergies									
Asthma									
Eczema									
Cancer (type)									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Diabetes									
Obesity									
Gastrointestinal Problems									
Thyroid Disease									
Psychological Problems									
ADHD									
Seizure									
Eye Problems									
Bleeding Problems									
Problems with Anesthesia									
Other									

I understand copies of the PATIENT'S FINANCIAL RESPONSIBILITY DISCLOSURE, CONSENT FORM, NOTICE OF PRIVACY PRACTICES and VACCINE POLICY are posted on the CHILDREN'S PHYSICIANS website and are available in the office. I understand that I am bound by the terms of the policies and failure to do so could result in dismissal.

Signature:_____ Relationship to Patient: _____

Printed Name: _____ Date: _____

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