The Pediatric Center

Patient Name:_____

Family Medical History

Do you or your family currently have or had any of the following illnesses?

	Self	Father	Mother	Siblings	Comments
Asthma					
Anemia					
High Blood Pressure					
Allergies					
Heart Disease					
Heart Murmur					
Cancer					
Diabetes					
Epilpsey					
High Cholesterol					
Tuberculosis					
Hepatitis					
HIV or Aids					
ADHD or ADD					
Bladder Disease					
Kidney Disease					

Patient Medical History

Have you ever had any surgery? Yes No

If yes, please list procedure and date _____

Have you ever been hospitalized? Yes No

If yes, when and why? _____

Current Medications:

Name Strength Frequency

Is patient allergic to any medications?

Yes No

Was the patient a product of a full-term pregnancy? Yes No

If no, how preterm? _____ weeks

Does the patient attend school or daycare? Yes No

If yes, what school or daycare? _____

Is patient current on all immunizations? Yes No