



Patient's Name: _____

Mom's Name: _____

Dad's Name: _____

ALLERGIES - Please list the patient's drug, food, or other allergies:

<input type="checkbox"/> No known drug allergies Or, List drug allergies:
<input type="checkbox"/> No food or other allergies Or, List food/other allergies:

MEDICATIONS - Please list the patient's medications and supplements:

Medication Name	Dose	Medication Name	Dose
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PAST MEDICAL HISTORY - Please list the patient's medical conditions:

1.	5.
2.	6.
3.	7.
4.	8.

PAST SURGICAL HISTORY – Please list the patient's previous surgeries and approximate dates:

Operation	Date/Location	Operation	Date/Location
1.		5.	
2.		6.	
3.		7.	
4.		8.	

BIRTH RECORDS:

Birth Facility: _____

Facility City, State: _____

The following information **MUST** match birth records:

Patient's Date of Birth: _____

Patient's Name (First, Last): _____

Birth Mother's Name (First, Last): _____

Birth Mother's Social Security Number: _____

IMMUNIZATION HISTORY:

Please attach a complete shot record.

If you do not have a complete shot record, please list all facilities where the patient has received immunizations:

Patient Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY

Is the patient adopted? Yes No

Parents: Mother: Alive Deceased Father: Alive Deceased

Sibling(s): Sister(s): How many alive? _____ How many deceased? _____
 Brother(s): How many alive? _____ How many deceased? _____

Please complete the section below if NOT adopted:

FAMILY HISTORY: Please indicate with a check for relatives with any of the following conditions:								
Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Anemia								
Asthma								
Autoimmune Disorder								
Bleeding Problems								
Cancer, Breast								
Cancer, Other								
Birth Defect								
Depression								
Diabetes								
Eczema								
Epilepsy								
Genetic Disorder								
Hay Fever/ Allergies								
Hearing Disorder								
High Cholesterol								
High Blood Pressure								
Immune Disorder								
Kidney Disease								
Learning Disability								
Stroke								
Sleep Apnea								
Substance Abuse								
Thyroid Disorders								
Tobacco Use								
Tuberculosis								
Death before age 56								
Other:								

SOCIAL HISTORY:

Who lives at home with the patient?

1.	4.	7.
2.	5.	8.
3.	6.	9.

Are your child's parents: Married Unmarried Separated/Divorced – if so, when? _____

Mother's Occupation: _____

Father's Occupation: _____

Child Care Situation: Parents
 Other's (Specify who/where) Example "Daycare-MDO": _____

Is Violence at home a concern? Yes No