Professional Park Pediatrics:
Patient Information and Medical History

Patient Information

Name:_____ Birth Date:_____ Sex (Circle): M F

Primary Language Spoken:_____Race/Ethnicity:_____

Home Address: _____

Parent Information:

□***Mom*** □***Dad:*** Name:_____Birth Date:_____Employer:_____

□***Mom*** □***Dad:*** Name:_____Birth Date:_____Employer:_____

□***Mom*** □***Dad:*** Cell Number:_____Work Number:_____Alternate Number:_____

□***Mom*** □***Dad:*** Cell Number:_____Work Number:_____Alternate Number:_____

Referred By:_____Child's Primary Physician:_____

Patient's History (If "Yes" to any, please explain)

Type of Delivery (*Circle*): Vaginal C-Section

Birth Length: Birth Weight:

Head Circumference: APGAR:

Delivery Complications: No Yes:

Newborn Complications: No Yes:

Chickenpox Disease: No Yes: Year:

Allergies: No Yes:

Hospitalizations: No Yes:

Surgeries: No Yes:

Previous/Ongoing Major Illnesses: No Yes:

Medications Taken Regularly: No Yes:

Mother's History (If 'Yes' to any, please explain)

Number of Pregnancies:_____ Number of Full Term Deliveries:_____Number of Preemies:_____Number of Living Children:_____

Blood Type (If Known):_____Complications of Pregnancy: No Yes:_____

Family History (If "Yes" to any, please explain)

Have any family members (including grandparents and great-grandparents) had any of the following? Circle and explain below.

Diabetes T.B. Cancer Epilepsy/Seizures Muscle weakness Tremors Anemia/Low Blood Sickle Cell

High Cholesterol Bleeding Problems Hay Fever/Allergies Asthma Sinus Chronic Bronchitis Stroke

Heart Attack High Blood Pressure

Details:

□ Mom's □ Dad's Health Issues: No Yes:

□ Mom's □ Dad's Health Issues: No Yes: