

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 Allergies: No Yes:

Birth Length: _____ Birth Weight: _____ Hospitalizations: No Yes:

Head Circumference: _____ APGAR: _____ Surgeries: No Yes:

Delivery Complications: No Yes: Previous/Ongoing
Major Illnesses: No Yes:

Newborn Complications: No Yes: Medications Taken
Regularly: No Yes:

Chickenpox Disease: No Yes: Year: _____

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

Number of Pregnancies: _____ Number of Full Term Deliveries: _____ Number of Premies: _____ 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: