Birth History

Patient name: _____

Hospital _____ Obstetrician _____Type of delivery _____

Complications with delivery _____

Birth weight _____ Birth length _____ Discharge weight _____

Health History

Patients previous physician _____ City _____ Phone _____

Date of last physical exam? _____ Results _____

	Yes	No
Is child under care of a physician now?	☐	☐
Receiving any medications or drugs?	☐	☐
Has your child been hospitalized?	☐	☐

Medications _____

_____

Immunizations up-to-date ☐ Yes ☐ No

Date Reason Hospital

_____

_____

Allergies _____

_____

Previous Surgeries:

_____

_____

Past or current medical problems:

_____

_____

Family History

Family history of medical problems:

_____

_____

Please list any siblings name and age:

_____

_____

Problem List

(Office use only)

Problem List

Problem:	Date:

Problem:	Date: