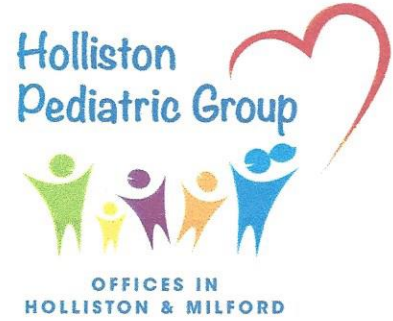


PATIENT NAME _____
PATIENT DOB _____



Medical History Review

Today's date: _____

Your Pediatrician (please circle): Gfeller Heppen Kula Kumar
 Ryan Urban Vespole Zisblatt

Past Medical History

Any complications with pregnancy or birth? No Yes (describe): _____

Was your child born: early late on time Birthweight: _____

Has your child ever had an allergic reaction to:

- Medicine? No Yes (describe) _____
- Food? No Yes (describe) _____
- Animals? No Yes (describe) _____
- Insect bites? No Yes (describe) _____

What medications does your child take on a regular basis? _____

Hospitalizations (when/where/why): _____

Surgeries (when/where): _____

Serious injuries (when/where): _____

Other significant past history? (i.e. asthma, seizures, diabetes, migraines)

PATIENT NAME _____

PATIENT DOB _____

Family History

Biological Mother's age: _____ Mother's health history: _____

Biological Father's age: _____ Father's health history: _____

Sibling (name/age):

1) _____

3) _____

2) _____

4) _____

Please check any of the following if present in your family: (indicate family relationship to patient)

Alcoholism _____

Diabetes _____

Allergic rhinitis _____

Drug Problem _____

Anemia/Blood disorder _____

Epilepsy/Seizures _____

Arthritis _____

Heart disease _____

Asthma/Reactive airway disease _____

High cholesterol _____

Attention Deficit Disorder (ADD) _____

Learning issues/Developmental delay _____

Birth defects _____

Melanoma _____

Blood clots _____

Migraine _____

Cancer _____

Stroke _____

Colitis _____

Sudden cardiac death _____

Deafness _____

Sudden infant death _____

Depression/Anxiety _____

Thyroid problems _____

Do any other medical problems/illnesses run in your family? Yes No

If yes, please describe: _____

Social History

Parents' name and occupation: Parent 1: _____

Parent 2: _____

Parents: Single Married Separated Divorced Widowed

Which parent(s) does your child live with: _____

Who else lives at home with your child? _____