Patient's Full Legal Name: (Last, First, Middle)

_____ DOB: _____

Patient Medical History **Today's Date:**

Current Status

Are your child's vaccines up to date? Yes No

Does your child have any significant allergies to: **Medication** Yes No **Food** Yes No **Environmental** Yes No

List allergies	Reaction	List allergies	Reaction
1)		3)	
2)		4)	

Does your child have any significant/major current health problems? Yes No **Please List Below:**

1)	4)
2)	5)
3)	6)

Do you have any concerns about your child's: **Development?** Yes No **Behavior?** Yes No **Social Skills?** Yes No **Schooling?** Yes N o

Birth History

Prematurity: Yes No **Weeks?** _____ **Birth Weight** _____Lbs. _____Ounces **Discharge Weight :** _____Lbs.. _____Ounces

Problems during Pregnancy or Delivery?	Yes No **List:**	**Infant Feeding:**	Breast Bottle Both
Any use of alcohol, tobacco, drugs or medications during pregnancy	Yes No **List:**	**Newborn hearing screening passed?**	Yes No
Was the baby in the NICU?	Yes No **List:**	**Metabolic screening (heel stick) Done**	Yes No

Patient's Medical History

Check appropriate boxes	*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
ADHD			Cancer			Hearing Problems		
Allergies			Chickenpox Year: _____			Heart Disease/Murmur		
Anemia			Congenital Anomalies			Mental Health Issues		
Asthma (recurring wheezing)			Constipation			Mononucleosis		
Autism			Developmental Delay			Pneumonia		
Bedwetting			Diabetes			Seizures		
Bladder/Kidney Disease (UTI's)			Eye Problems			Skin Issues (eczema, acne)		
Blood Disease			Failure to Thrive			Sleep Issues		
Blood Pressure, High			G. I. Problems			Thyroid Disease		
Blood Transfusions			GERD (reflux)			Other Medical History:		
Broken Bones			Headaches/Migraines					

Patient's Hospitalization & Surgical History

Has your child even been hospitalized (overnight?) Yes N o **Has your child ever had surgery?** Yes N o

Reason	*Date*	*Reason*	*Date*
1.		3.	
2.		4.	

Thank you for choosing Pediatric Partner