PATIENT NAME:_____AGE:_____ BIRTHDATE:_____

DATE OF LAST EXAM:_____ FOR WHAT:_____

HOW MUCH DID YOUR CHILD WEIGH AT BIRTH?_____LBS. _____OZ.

FOLLOWING BIRTH, DID YOUR CHILD HAVE ANY UNUSUAL PROBLEMS?_____ IF SO, PLEASE DESCRIBE:

_____

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS?_____ IF SO, PLEASE LIST THEM:

_____

IS YOUR CHILD TAKING ANY MEDICATIONS?_____ IF SO, PLEASE LIST THE NAME AND DOSE:

_____

HAS YOUR CHILD HAD ANY OPERATIONS?_____ IF SO, PLEASE LIST THE TYPE AND DATE:

_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED?_____ IF SO, FOR WHAT REASON AND AT WHAT AGE:

_____

ARE THERE ANY ILLNESSES THAT RUN IN THE FAMILY?_____ IF SO, PLEASE LIST THEM:

_____

PLEASE GIVE THE DATES OF THE FOLLOWING IMMUNIZATIONS:

DTP						VARICELLA			
POLIO						HEPATITIS B			
MMR						MEASLES			
DT						MUMPS			
TETANUS						RUBELLA			
HIB						TB TEST			

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING ILLNESSES: (please circle)

Anemia	Hayfever	Eczema	Food allergies
Diabetes	Bronchitis	Hives	Kidney trouble
Convulsions	Pneumonia	Trouble hearing	Bladder infections
Asthma	Heart murmur	Trouble seeing	Any disabling physical condition

GIRLS ONLY:

HAVE YOU HAD YOUR FIRST MENSTRUAL PERIOD?_____ IF SO, AT WHAT AGE?_____