Pediatric Form (Ages Birth - 12 years)

Patient's Name________________________________ Date______________
Age_______ Date of Birth_________________ Gender: Male____ Female_____
Mothers Name________________ Fathers Name______________________
Address_________________________________ City_______ State___ Zip____
Phone (H)______________ (W)________________ (C)__________________
How did you hear about our clinic_____________________________________
Health Insurance company__________________________Policy #__________
ID #______________ Name on Policy____________ Relationship to child_______
Name of Hospital/Clinic/Office where your child's health records are kept:
____

Reason for visit or presenting problems:
____
____

Medications: ____
Past Medications:____
Medical History any of the following: **Please circle**

Chicken Pox	Scarlet Fever	Tonsillitis #_____
Measles	Pneumonia	Ear Infections #______
Mumps	Frequent Colds	Other ______________
Rubella	Rheumatic Fever	

Has your child had any of the following tests: **Please circle**
Electroencephalogram
Psychological exam
Haring
Speech/Language
Injuries/Surgeries/Hospitalizations.

If any circled please
explain:____
____

Diet: Breakfast____
Lunch________________________________/Dinner__________________________
Drinks____________________ Allergies to food__________________________________

Shot Record: Please circle
Tetanus/Pertussis/Diphtheria Measles Chicken Pox HPV Flu Shot
Polio
Any adverse reactions?____
____

Please list any supplements or medications including vitamins your child is currently taking. Please list doses and directions:____
____

Anything else you would like to add:____
____

Thank you so much. Please know your child's well being is very important to us and we are honored that you have chose our office for your child's health care needs. Should you have any questions at any time please feel free to ask.