

Patient Medical History

Birth history: Full-term Premature, _____ wks Post-term, _____ wks
 Vaginal C-section, reason: _____ Birth weight: ____ lbs ____ oz
 Maternal complications? No Yes, explain: _____
 Infant complications? No Yes, explain: _____

Developmental: Sat _____ mo Crawled _____ mo Walked _____ mo Talked _____ mo
 School progress: _____

Allergies (medication/food/other)? No Yes, please list: _____

Medications? No Yes, please list: _____

Chronic Illnesses? No Yes, please list: _____

Hospitalizations? No Yes, please list: _____

Surgeries? No Yes, please list: _____

Family History

Heart disease	Family member (relationship to patient)		Family member (relationship to patient)
Kidney disease		Diabetes	
Allergies		Seizures	
Asthma		Eye disease	
Hypertension		Anemia	
Infant deaths		Sickle Cell disease/trait	
Bleeding disorders		Cystic fibrosis	

In case of emergency

In the event of my absence, the following people have my authorization to bring my child for medical treatment:

Name	Relationship to patient	Phone number