Families First Pediatrics
PATIENT HISTORY

CHILD'S NAME: (Last, First, M) ____

Date of Birth: (mm/dd/yyyy) _______________________**Race:** __________________

(If the answer to a question is **YES**, please list proper information)

Medications:

What are your child's current medications?
Medication________________ Dosage_______________
________________ _______________
________________ _______________
Are there any allergies to any medications? ____________________________________

Social History:

Is there smoking in this child's home? ______________
Does this patient use tobacco, alcohol or other drugs? ___________________
Other: ____

Serious Illnesses:

Has this child had any serious illnesses in the past? ______________________________
Has this child been diagnosed with Chronic Lung Disease? Yes No
Has this child been diagnosed with Congenital Heart Disease? Yes No
Does this child have a 'chronic disease' now? (diabetes, asthma, heart problems, etc)__ ___________
Were there any abnormalities at birth? ____
Was there any problem during the pregnancy or delivery of this child? _______________
Was this child born at or before 36 weeks gestation? Yes No
Is this child being treated any other physicians for any special problems at this time?
Name__________________________________ Phone___________________________

Operations:

Has this child ever had surgery of any kind? ____________________________________
Has this child ever been hospitalized? ____

Allergies:
____
____
____

Family History: (i.e Cancer, diabetes, heart problems, etc)
____
____
____

Does this child attend day care? _______Name__________________Phone___________