BOONSLICK PEDIATRICS NEW PATIENT HISTORY

PLEASE COMPLETE EACH LINE WITH EITHER A RESPONSE OR "NONE"

DATE:_____

PATIENT'S NAME:_____ MALE____FEMALE____DATE OF BIRTH:_____
MOTHER'S NAME:_____ FATHER'S NAME:_____
PATIENT RESIDING WITH:_____

REASON FOR THE VISIT:_____
_____

MEDICAL HISTORY: (Include previous medical problems or illness treated by another physician)
Problem:_____Physician:_____Date:_____
Problem:_____Physician:_____Date:_____
Problem:_____Physician:_____Date:_____

PREVIOUS SURGERIES, SERIOUS ILLNESS, INJURIES, HOSPITALIZATIONS:
Problem:_____Date:_____
Problem:_____Date:_____
Problem:_____Date:_____

CURRENT MEDICATIONS AND DOSAGE: (Include any over the counter medications including Tylenol, vitamins, cold and allergy medications)_____ _____
_____ _____
_____ _____

ALLERGIES: (Include foods, medications, pollen, dust, insect stings, etc. and describe reaction)
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____

CHILD'S FAMILY INFORMATION: (Your Child's Siblings)
Sibling:_____ Age:_____
Sibling:_____ Age:_____
Sibling:_____ Age:_____
Sibling:_____ Age:_____

FAMILY MEDICAL HISTORY: Please list below any illnesses experienced by parents, grandparents, or siblings such as Allergies, Asthma, Birth Defects, Bleeding Tendencies, Blood Disease, Cancer, Diabetes, Eczema, Emphysema, Epilepsy, Heart, Attack, Heart Defect, Heart Disease, High Blood Pressure, Gastrointestinal Disease, Kidney Disease, Liver Disease, Mental Disorder, Developmental Delay or Learning Disability, Thyroid Disease, Others. Indicate which relative has what type of illness. For example: "Grandmother (indicate if this is Mom's mom or Dad's mom or Mom's grandma or Dad's grandma)-lung Cancer or Sister (child's sister)-asthma.
Relationship:_____ Disease:_____
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Relationship:_____ Disease:_____