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PEDIATRIC MEDICAL HISTORY

TODAY'S DATE: (mm/dd/yy)

Physician Name: Select from list below

OR Enter Physician Name Below:

PATIENT INFORMATION

PATIENT NAME: (First)		(Middle)	(Last)
ADDRESS: Street Name and #		City, State	Zip Code
TELEPHONE (Home):		TELEPHONE (Business):	

GUARANTOR NAME: (First)		(Middle)	(Last)
RELATIONSHIP OF GUARANTOR TO PATIENT:			
ADDRESS: Street Name and #		City, State	Zip Code
TELEPHONE (Home):	TELEPHONE (Business):	E-MAIL:	

DEMOGRAPHIC INFORMATION

DATE OF BIRTH: (mm/dd/yy)	AGE:	SEX:	NAME OF EMPLOYER:
MARITAL STATUS:	LANGUAGE PREFERENCE:	OCCUPATION:	

REFERRAL INFORMATION

HOW WERE YOU REFERRED?: *SELECT ONE*

WEBSITE INSURANCE FAMILY / FRIEND PHYSICIAN EMERGENCY ROOM

OTHER (*specify*) _____

BRAIN/SPINE ORGANIZATION (*specify*) _____

REFERRING PHYSICIAN:	PHONE #:	FAX #:
ADDRESS: (Number, Street, City, State and Zip)		
PRIMARY CARE PHYSICIAN:	PHONE #:	FAX #:
ADDRESS: (Number, Street, City, State and Zip)		
SUB-SPECIALIST (1):	PHONE #:	FAX #:
ADDRESS: (Number, Street, City, State and Zip)		
SUB-SPECIALIST (2):	PHONE #:	FAX #:
ADDRESS: (Number, Street, City, State and Zip)		

PEDIATRIC MEDICAL HISTORY (Continued)

PATIENT NAME: _____

HEALTH INFORMATION

REASON FOR TODAY'S VISIT: _____

OTHER DISEASES AND/OR PROBLEMS: _____

BIRTH HISTORY INFORMATION

ROUTE OF DELIVERY: (SELECT ONE)
 VAGINAL C-SECTION

GESTATIONAL AGE OF DELIVERY: _____

PERINATAL COMPLICATIONS: _____

HEAD CIRCUMFERENCE AT MOST RECENT PEDIATRICIAN OFFICE VISIT: _____ DATE PERFORMED: (mm/dd/yy) _____

LIFESTYLE INFORMATION

DO YOU SMOKE?
 NO YES How many packs a day _____ How many years _____ QUIT - When _____

DO YOU DRINK ALCOHOL?
 NO YES How often _____ How much _____

DO YOU USE RECREATIONAL DRUGS?
 NO YES Which drugs _____ How often _____

DO YOU EXERCISE REGULARLY?
 NO YES How often _____ What type of exercise _____

Please check (✓) if you have experienced any of the following medical problems:

SELECT ALL THAT APPLY

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney/ Urinary Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Bleeding/ Clotting Disorder | <input type="checkbox"/> Numbness or Pain in: |
| <input type="checkbox"/> Cancer (describe below) * | <input type="checkbox"/> fingers <input type="checkbox"/> toes <input type="checkbox"/> arms <input type="checkbox"/> legs |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Neuromuscular Diseases |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Difficulty Speaking | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Stomach/ Intestinal Problems |
| <input type="checkbox"/> Dizziness/ Fainting | <input type="checkbox"/> Stroke/ CVA |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Swelling Arms / Legs |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Glaucoma/ Cataracts | <input type="checkbox"/> Thyroid/ Parathyroid Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Transplant (donor/recipient) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Ulcer (GI/Duodenal) |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Unplanned Weight Loss |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Weakness in Arms / Legs |
| <input type="checkbox"/> High Blood Pressure | |

* If applicable - Describe Cancer Type: _____

PEDIATRIC MEDICAL HISTORY (Continued)

PATIENT NAME: _____

FAMILY HISTORY

Please check (✓) if anyone in your family has had any of the following:

SELECT ALL THAT APPLY

- | | | |
|--|---|--|
| <input type="checkbox"/> Clotting/ Bleeding Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke/ CVA |

FATHER:

Alive Deceased- Age at Death _____ Cause _____

MOTHER:

Alive Deceased- Age at Death _____ Cause _____

SIBLINGS: - How Many _____

Alive Deceased- Age at Death _____ Cause _____

Alive Deceased- Age at Death _____ Cause _____

Alive Deceased- Age at Death _____ Cause _____

Alive Deceased- Age at Death _____ Cause _____

Alive Deceased- Age at Death _____ Cause _____

Alive Deceased- Age at Death _____ Cause _____

Please check (✓) if you have been hospitalized for a reason other than surgery:

REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:

Please check (✓) if you have ever had surgery (describe below):

REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:

PEDIATRIC MEDICAL HISTORY (Continued)

PATIENT NAME: _____

MEDICATIONS

Please list any medications you are currently taking (including herbal or over-the-counter preparations)

MEDICATION NAME	DOSAGE	HOW ADMINISTERED *
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

* Oral, Injection, IV, etc.

Are you presently taking aspirin or have you taken aspirin in the past 7 days? Yes No

Please check (✓) if you are allergic to any medications or latex and (describe below):

NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:

PREFERRED PHARMACY

NAME:	TELEPHONE #:	ADDRESS:
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I believe the above information is complete to the best of my knowledge:

Patient Signature: _____ Date: _____

If this form was completed by someone other than the patient, please list name, relationship to the patient and the reason that the patient was unable to complete the form:

HOSPITAL
USE ONLY

Reviewed and Discussed
With Patient: _____

SIGNATURE

Date: _____