Pediatric & Adolescent Center Patient History **Date:_____** 1

PATIENT'S NAME: _____Date of Birth:_____
ADDRESS:_____
PHONE:_____ SSN: _____ SEX:_____
REFERRED BY: _____PREVIOUS DOCTOR: _____Dr's Tel#_____

BIRTH HISTORY: ADOPTED? YES___ NO___ If yes is child aware? Yes_____ no_____
Hospital born at:_____Birthweight_____ Length_____
Full Term or Premature? (circle one) Type of Delivery Vaginal C-Section (circle one)
Complications during delivery?_____
Nicu or special care nursery? Yes_____ no _____
Problems after birth or during first week?_____

SOCIAL HISTORY: Who does child live with?_____

Mother's Name:_____	Father's Name:_____
Date of Birth:_____	Date of Birth:_____
Health:_____	Health:_____
Occupation:_____	Occupation:_____
Employer:_____	Employer:_____
E-Mail:_____	E-Mail:_____
SSN:_____	SSN:_____
Cell#_____	Cell#_____
Work#	Work#

Parents' Marital Status: Married___Divorced____Never Married____Separated_____Single____
If divorced, who has legal custody?_____
Any smokers? Yes____ No _____ if yes who?_____
Brother:_____ age:_____ health:_____
Brother:_____ age: _____health:_____
Sister:_____age:_____health:_____
Sister:_____age:_____health:_____

ALLERGIES:_____

CURRENT MEDICATION:_____

PAST MEDICAL HISTORY: (circle all that apply) Chickenpox, Mono, Pneumonia, Seizure, Heart Murmur, Wheezing/ asthma, Diabetes, Skin Problems, TB, Bowel Problems, Bladder infection, Bed wetting, Behavioral problems, sickle cell, Bleeding disorder, others:_____

FAMILY HISTORY: (circle all that apply) Tb, Asthma, Heart attack before age 40, Diabetes, Convulsions, Heart Disease, Hypertension, Arthritis, Bleeding Disorder, Muscle Disorders,
Sudden Infant Deaths, others,_____

EMERGENCY CONTACT

NAME:_____RELATIONSHIP:_____
ADDRESS:_____ CONTACT # _____

Parent/Guardian Signature: