

THE PEDIATRIC CENTER

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Please take a moment to give us some information on each of your children and your family.

Name of child:		Date of Birth:	
Allergies (food, drugs or environment)	Date of onset	type of reaction	
(1) _____	_____	_____	
(2) _____	_____	_____	
(3) _____	_____	_____	
Current Medications:	Name	dose	frequency
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
Major Medical problems (Hospitalizations, Surgery, etc.)			
(1) _____			
(2) _____			

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(1) _____	_____	_____	
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(3) _____	_____	_____	
Current Medications:	Name	dose	frequency
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
Major Medical problems (Hospitalizations, Surgery, etc.)			
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(1) _____	_____	_____	
(2) _____	_____	_____	
(3) _____	_____	_____	
Current Medications:	Name	dose	frequency
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
Major Medical problems (Hospitalizations, Surgery, etc.)			
(1) _____			
(2) _____			

Please ask for another sheet for additional children

FAMILY HISTORY

On either side of the family, could you let us know if these conditions are present, and who has them? If the history is unknown, write a “U” next to the items. If you are unsure, put a “?”.

<u>Condition</u>	<u>Who Might Have It</u>
Early Heart Disease (Sudden death, heart attack < 55yo)	
Elevated Cholesterol	
Elevated Blood Pressure	
Lung problems (asthma, tuberculosis)	
Allergies (drugs, food or seasonal)	
Liver problems (hepatitis, cirrhosis)	
Blood disorders (anemia, excessive bleeding, low platelet)	
Kidney problems (stones, failure)	
Digestive problems: (colitis, ulcers, gastritis, celiac)	
Neurological problems (seizures, migraines)	
Thyroid gland problem	
Diabetes (adult or juvenile)	
Obesity	
Emotional difficulties (depression, anxiety, OCD, panic)	
Cancers	
Congenital defects	
Learning difficulties (ADD, PDD, autism)	
Substance use (alcohol, prescription or street drugs)	

SOCIAL HISTORY

Who lives at home: (please include family, extended family and caregivers):

Do you live in (circle): apartment/condo house

List any pets:

Do you have well water or town water:

Does anyone in the home use tobacco:

If you would like to receive occasional information by email, please give us your email address below. (We will not provide your email address to any third party)

Email _____

