

CRESTWOOD PEDIATRICS ASSOCIATES, PC

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PATIENT HISTORY FORM

ACCOUNT: _____

Child's Last Name: _____ First Name: _____

Date of Birth: _____ Sex: ___ M ___ F Birth Weight _____

Father's Name: _____ DOB: _____

Mother's Name: _____ DOB: _____

Child's Previous Physician: _____

Were there any problems during pregnancy, labor or delivery? _____ YES _____ NO

If yes, please explain: _____

Type of Feeding: _____ Breast _____ Formula Type: _____

Were there any problems during the first 6 months of life: _____

Has the child had any chronic or significant past illnesses, surgeries or hospitalizations?

Current/Chronic Medications: _____

Specialists Following Child: _____

Are there any allergies to any Medications? _____

FAMILY MEDICAL HISTORY

Please include child's immediate family: Parents, Grandparents, Brothers, Sisters only:

Circle yes or no, if yes, give relationship, (i.e. Maternal grandmother)

Heart Disease YES NO _____

Tuberculosis YES NO _____

Seizures YES NO _____

Ear/Eye Problems YES NO _____

Mental Retardation YES NO _____

Chest/ Lung Problems YES NO _____

Stomach/Colon Problems YES NO _____

Kidney Problems YES NO _____

Arthritis/Bone/Joint Problems YES NO _____

Diabetes YES NO _____

Cancer YES NO _____

High Blood Pressure YES NO _____

High Cholesterol YES NO _____

Mental Illness YES NO _____

AIDS/HIV YES NO _____

Signature of Parent/Guardian: _____ Date: _____