

PRIMARY PEDIATRIC MEDICAL GROUP
INITIAL VISIT - MEDICAL INFORMATION

Name _____ Birth date _____ Today's date _____

FAMILY HISTORY

Father: Name _____ Age _____

Health _____

Mother: Name _____ Age _____

Health _____

Do the child's parents, siblings, aunts/uncles or grandparents have any of the following health issues?

Allergies / Asthma _____

Diabetes _____

High blood pressure requiring medication _____

High cholesterol or heart attack under the age of 60 _____

Cancer _____

Disorders known to run in the family (e.g. seizures, anemia, bleeding disorders, ADD/learning disabilities, celiac disease, vision or hearing problems)

BIRTH HISTORY

Birth weight _____

Newborn condition _____

Feeding _____

PAST MEDICAL HISTORY (the patient) Previous pediatrician _____

Drug allergies _____ None _____ Yes: _____

Hospitalizations _____ None _____ Yes: _____

Surgeries _____ None _____ Yes: _____

Chronic conditions _____ None _____ Yes: _____

Developmental/
School Problems _____ None _____ Yes: _____

SCHOOL: _____