

MEDICAL RECORD

PATIENT INFORMATION

Date of 1st visit _____

Name _____ Age _____ Gender _____ DOB _____

Parent Name _____ Employer _____

Parent Name _____ Employer _____

Home Address _____

Primary Phone _____ Secondary Phone _____

Marital Status of Parents _____ Referred by _____

FAMILY MEDICAL HISTORY

Significant Family Medical History (i.e. diabetes, cardiac disease, cancer, diseases particularly affecting children)

Known Allergies of Patient _____ Known Allergies of Parents _____

INFANT HISTORY

Birth Weight _____ Delivery C-Section Vaginal _____

Apgar Scores (if known) _____ Term Pre-Term Post Term

Hospital _____ Delivered by _____

Significant Neonatal Problems

- Respiratory Difficulties
- Hyperbilirubinemia
- Prematurity
- Low Apgars/Asphyxia
- Other _____

Feeding History

Breast Formula
Type _____

IMMUNIZATION HISTORY

CHILDHOOD MEDICAL HISTORY

- Chronic Diarrhea
 - Frequent Colds
 - Ear Infections
 - Allergies
 - Asthma
 - Serious Illnesses or Hospitalizations
 - Developmental Problems
 - Others
- Description of above _____

		Date	Lot#	Given by
DPT	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
	5	_____	_____	_____
OPV	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
	5	_____	_____	_____
MMR	1	_____	_____	_____
	2	_____	_____	_____
HIB	1	_____	_____	_____
	2	_____	_____	_____
TINE	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
Other	1	_____	_____	_____