MEDICAL RECORD

Date (first visit) ____________________

I PATIENT INFORMATION

Name ____________________ Age ________ Sex ________ DOB ________

Name to be called ____________________

Phone (Home) ____________________

Parent's Name ____________________

Phone (Work-Father) ____________________

Home Address ____________________

Phone (Work-Mother) ____________________

Employer of Father ____________________

Marital Status of Parents ____________________

Employer of Mother ____________________

Referred by: ____________________

II FAMILY MEDICAL HISTORY

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

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Known Allergies of Patient ____________________

Known Allergies of Parents ____________________

III INFANT HISTORY

Birth Weight ____________________

Delivery: ☐ C-Section ☐ Vaginal ____________________

Apgar Scores (if known) ____________________

☐ Term ☐ Pre-Term ☐ Post Term

Where Delivered ____________________ Who Delivered ____________________

Significant Neonatal Problems

- ☐ Respiratory difficulties
- ☐ Hyperbilirubinemia
- ☐ Prematurity
- ☐ Low apgar/asphyxia
- ☐ Other ____________________

Feeding History ☐ Breast ☐ Formula

Type ____________________

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IV CHILDHOOD MEDICAL HISTORY

- ☐ Chronic Diarrhea or Constipation
- ☐ Frequent Cold
- ☐ Ear Infections
- ☐ Allergies
- ☐ Asthma
- ☐ Serious illnesses or hospitalizations
- ☐ Developmental Problems
- ☐ Other

Description of above: ____________________

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V IMMUNIZATION HISTORY

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