Past Medical History

Patient Name _____ Age: _____ Sex: M or F

Allergies:_____

Current Medicines:_____

Medical History

BIRTH HISTORY (Please list birth weight, any pregnancy complications or birth complications)

_____

_____ONGOING

ILLNESSES (Please list any ongoing medical illnesses. i.e. Asthma, Eczema, Heart Murmurs, etc.)

_____

_____

Hospitalizations / Surgeries

(Please list any hospitalization and/or surgeries, include dates and reasons)

_____

_____

_____

Family History

(Please list any history of medical conditions or genetic disorders for immediate family members: parents and siblings)

_____

_____

_____

Social History

Are birth parents married to each other? Y N

Smokers at home? Y N

Is patient in daycare? Y N

Pets at home? Y N

Family Religion?_____

Types of pets?_____

Responsible Party Name (Print): _____

Responsible Party Signature: _____ Date: _____