MEDICAL/SURGICAL HISTORY REVIEW

Patient's Full Name: _____

Date of Birth: _____

Where was patient born? Hospital _____ City _____

Were there any problems at birth? Yes _____ No _____

If Yes, Please explain: _____

Has patient ever been hospitalized? Yes _____ No _____

If Yes, Please list: _____

Has patient ever had any surgeries? Yes _____ No _____

If Yes, Please list: _____

_____

Please list any ALLERGIES: _____

Does patient have any chronic or long term problems?: Yes _____ No _____

If Yes, Please explain: _____

Does patient currently take any MEDICATION?: Yes _____ No _____

If Yes, Please list: _____

Does the child's mother or father have any medical or surgical problems or illnesses?: Yes _____ No _____

If Yes, Please explain: _____

Does any family member have any condition we should be aware of?: Yes _____ No _____

If Yes, Please explain: _____

Do you feel patient's development is normal?: Yes _____ No _____

If No, Please explain: _____

Please list all other doctors, dentist, therapists, and specialists your child has seen.

_____ _____

_____ _____

_____ _____

_____ _____

Is there any other information you would like for us to know?

_____

Person Completing Form_____ **Relationship to Patient**_____**Date**_____

Review by medical staff: _____ Initials _____ Date

Scan: _____ Yes _____ No _____ Return paper to doctor

Scan and message doctor for review: _____ Initials Account # _____