PATIENT HISTORY

Port Orange Pediatrics, PA

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Today's Date____

Patient's Name						Date of Birth		
		я 1	Patie	ent's Past His	tory:		-	
1. At what age did your child Start Talking?							note	es:
2. Has your child had more than 4 ear infections?						Y N		
3. Does your child usually have more than 5 colds, sore throats or respiratory illness each year?								
4. Does your child usually get an ear infection after a cold?						Y N		
5. Does your child seem to have a continuous stuffy nose or constant cold?								
6. Has your child had "ASTHMA" or "WHEEZING"?								
7. Has your child had any feeding or gastrointestinal problems?								
8. Has your child had any problems with urination or urinary tract (kidney) infections?								
9. Has your child had any heart problems?						Y N		
10. Has your child ever had a convulsion or seizure?						Y N		
11. Has your child had any visual or eye problems?							•	
12. Has your child had any ALLERGIC REACTION TO MEDICATIONS? What?							•	
13. Have any of your children died?								
14. Has your child ever been hospitalized or had any surgery?						Y N		
What for?								
15. Does your child have any other medical or psychological problems that we should know about? Y N What?								
16. Do you have any concerns about your child's development?								
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			FAM	ILY HISTOR	RY			, 712 7121111
Please list any fan	nily memb	ers havir			parents, grandpar	ents, aunts, unc	les, and cous	ins.
			Answer as if	answering for ye	our child.			
Mark an "X" in the box to a	all that app	ly.						
	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling 1	Sibling 2
Obesity								
Cardiovascular Disease				·				
High Blood Pressure							·	
High Cholesterol								
Diabetes								
Thyroid Problems								
Asthma								
Allergies/Hay Fever								
Inherited Disorders							·	
Psychiatric Disorders								