kids first pediatrics

Patient's Name: _____

Mom's Name: _____

Dad's Name: _____

ALLERGIES - Please list the patient's drug, food, or other allergies:

☐ No known drug allergies Or, List drug allergies:
☐ No food or other allergies Or, List food/other allergies:

MEDICATIONS - Please list the patient's medications and supplements:

Medication Name	Dose	Medication Name	Dose
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

PAST MEDICAL HISTORY - Please list the patient's medical conditions:

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

PAST SURGICAL HISTORY – Please list the patient's previous surgeries and approximate dates:

Operation	Date/Location	Operation	Date/Location
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

BIRTH RECORDS:

Birth Facility: _____

Facility City, State: _____

The following information MUST match birth records:

Patient's Date of Birth: _____

Patient's Name (First, Last): _____

Birth Mother's Name (First, Last): _____

Birth Mother's Social Security Number: _____

IMMUNIZATION HISTORY:

Please attach a complete shot record.

If you do not have a complete shot record, please list all facilities where the patient has received immunizations:

_____

_____

_____

FAMILY MEDICAL HISTORY

Is the patient adopted? ☐ Yes ☐ No

Parents: **Mother:** ☐ Alive ☐ Deceased **Father:** ☐ Alive ☐ Deceased

Sibling(s): **Sister(s):** How many alive? __ How many deceased?
Brother(s): How many alive? _____ How many deceased? _____

Please complete the section below if NOT adopted:

FAMILY HISTORY: Please indicate with a check for relatives with any of the following conditions:								
Medical Condition	**Mom**	**Dad**	**Sister**	**Brother**	**Mom's Mom**	**Mom's Dad**	**Dad's Mom**	**Dad's Dad**
Anemia								
Asthma								
Autoimmune Disorder								
Bleeding Problems								
Cancer, Breast								
Cancer, Other								
Birth Defect								
Depression								
Diabetes								
Eczema								
Epilepsy								
Genetic Disorder								
Hay Fever/ Allergies								
Hearing Disorder								
High Cholesterol								
High Blood Pressure								
Immune Disorder								
Kidney Disease								
Learning Disability								
Stroke								
Sleep Apnea								
Substance Abuse								
Thyroid Disorders								
Tobacco Use								
Tuberculosis								
Death before age 56								
Other:								

SOCIAL HISTORY:

Who lives at home with the patient?

1.	4.	7.
2.	5.	8.
3.	6.	9.

Are your child's parents: ☐ Married ☐ Unmarried ☐ Separated/Divorced – if so, when? _____

Mother's Occupation: _____

Father's Occupation: _____

Child Care Situation: ☐ Parents

☐ Other's (Specify who/where) *Example "Daycare-MDO"*: _____

Is Violence at home a concern? ☐ Yes ☐ No