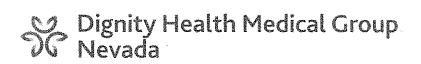


Please complete the form below. Your Pediatrician will review it with you at the time of your appointment.

Patient Information					
Last Name:	First Name:	Middle Initial:			
Date of Birth:/Age	e:				
Gender: Male / Female Marita	ol Status: M S D W	Race:			
Address:	Apt #:	□ Caucasian	□ Asian		
City: State:	ZIP:		can 🗆 Pacific Islander		
		☐ Hispanic/Latin			
		□ Do not wish to			
· · · · · — —		□ Other:			
Work Number: ()	NATE OF SERVICE				
Guarantor/Guardian Information (g	person responsible for pa	vment)			
Responsible Party:	,	,			
Name:	Relationship: _		Male / Female		
Date of Birth:	SSN:	· · · · · · · · · · · · · · · · · · ·	TO A STATE OF THE		
Address:	Apt #:				
City: State:	ZIP:				
Phone Number: ()	Cell Number:	()	*** **********************************		
Employer:	Work Number:	: ()			
Email Address:					
Additional Responsible Party:					
Name:	Relationship: _		Male / Female		
Date of Birth:/	SSN:				
Address:					
City: State:	ZIP:				
Phone Number: ()	Cell Number:	()			
Employer:	Work Number	: ()	***		
Fmail Address:					



Emergency Contact

Primary:	
Emergency Contact Name:	Relationship:
Home Phone: ()	Cell Phone: ()
Work Phone: ()	
Secondary:	
Emergency Contact Name:	Relationship:
Home Phone: ()	Cell Phone: ()
Work Phone: ()	
Primary Care / Referring Physicians	
Primary Care Physician:	_Phone Number: ()
Referring Physician:	Phone Number: ()
Insurance Information	
Primary Insurance:	
Insurance Name:	Plan Type: HMO PPO POS EPO Other
I.D. Number:	Group Number:
Subscriber's Name:	Date of Birth:
Employer:	Work Phone: ()
Secondary Insurance:	
Insurance Name:	Plan Type: HMO PPO POS EPO Other
I.D. Number:	Group Number:
Subscriber's Name:	Date of Birth:/
Employer:	

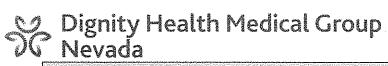
Medical History												
Review of Symptoms												
Within the last week has your child had any of the following symptoms												
			Ye s	N o			Ye s	No		***************************************	Yes	No
	Gene	ral	i i i i i i i i i i i i i i i i i i i			Respiratory				Neurologic		
Fever	***************************************			T	Cough				Headac	hes		
Night sweats/	chills				Whee	ing			Seizure	S		
Decreased ap	petite				Difficu	Difficulty breathing			Weakn	ess		
Increased cryi	ng				Cardiovascular					Psychiatric	AVIEN.	
	Skir	1			Shortness of breath				Change	in sleep pattern		
ltching					Chest pain				Fussine	SS		
Rash					Difficulty breathing on exertion				Endocrine			
New lesion	***************************************	************			1	ng while feeding (infants)			Changes in hair			
Excessive swe	ating					Gastrointestinal			Hematology			
Eyes/E		se/T	hroat		Abdon	ninal pain	<u> </u>		Easy Bruising			
Red eye(s)				<u> </u>	Vomiti	· · · · · · · · · · · · · · · · · · ·			Enlarged lymph nodes			
Excessive tear	ing	*			Diarrh	<u> </u>				Urologic		
Eye discharge			1	†		pation			Pain wi	th urination		
Earache		 		 		lty swallowing			Blood is	n urine		
Ear discharge						Musculoskeletal						
Runny nose					Decrea	sed range of motion						
Nasal congest	ion					e weakness	<u> </u>					
Sore throat		**********			Join pain/swelling							
	Nec	k			14.00		lm	muniza	tions			
Neck stiffness					Are yo	ur child's immunizations up to	o date?					
Swollen gland	5				If possible, please show us your child's vaccine record							
Has your child	had:		□ ci	nicken	Pox 🗆 N	Aeasles ☐ Scarlet Fever ☐ N	Mumps	□ Oth	er:			
Family His	olesia de la composición dela composición de la composición de la composición de la composición de la composición dela composición de la composición dela composición dela composición de la composición dela composición de la composición dela composición dela compos										25.0	
Is there a fai		tory o	of the f	ollowi	ng:							
··········	Ye	N		tionsh				Ye				
	S	0	Chile	2017-1-10				S	No	Relationship to C	hild	
Diabetes	:					Cancer	REEL					
Allergies						Heart Disease						
Convulsion s						Tuberculosis						
Asthma						Other			1			
Family Pro	ofile											
•	Name	1	Age	Hea	طعا	Child's Parents are: ☐ Ma	arriad	∏ Cona	ented []	Diversed T Other		
Parent	wante		Age	rie	31613	Highest level of Educatio		- Sepa		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	***************************************	
Parent				+		Highest level of Education?		Occupation Occupation				
Sibling				+		Number of people living in you		r house	····	Pation		
				 								
Sibling				-		Any smokers in your hou				utside? □ Yes □ N	D	
Sibling				 	Pets? ☐ Yes ☐ No What kind?							
Sibling				1	Number of people living with your child: t with anyone who is receiving chemotherapy, on medications							
1							emoth	erapy,	on medic	cations		
regularly suc	th as ste	eroid:	s or has	s had a	an organ	transplant? 🗆 Yes 🗀 No						

Medications				16 13 16 16 16	, 20 (A) (20 (C) (C) (A)			
Name	dose (mg)	times/day	Name		dose (mg)	times/day		

Pharmacy information								
Name:	·····	·	Phone:					
			Fax:					
Address:								
Past Medical History				8.808.808	654553	300000000000000000000000000000000000000		
Serious Injuries or Illness		7	Allergies:					
	·		Drugs: ☐ Yes ☐ No	Food: □ Y	es □ No La	tex: ☐ Yes ☐ No		
			nvironmental: 🗆 Yes	□ No				
			liergy Testing: ☐ Yes	Active resident for the end of the				
Hospitalizations (includin	g NICU at bir	<u>th):</u>	lease explain all Yes	answers:				

				····	*			
Surgeries:		1 14 4 1 1 1						
			dethmhoulded to the third to the thi					

Development								
School History:								
My child is in: □ Daycare □ Pro	acchaol (7 Bubli	o School C Drive	ato School Fi Homo S	chaol		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		
School Name:	SCHOOL & PUBLI	C SCHOOL - PILV	Year in School:	CHOOL		······································		
School Problems: ☐ Yes ☐ No				Discipline or Behavior Problems □ Yes □ No				
Has your child been seen by a Psychologist, Speech Therapist or Special Teachers? Yes No No								
			or openiar reactions.	- 103 - 140	**************************************			
Is your child in any special classes? □ Yes □ No Please explain any yes answers:								
r Nasc Capturi ary 703 arrowers.								
	A							
***************************************	***************************************			······	***************************************			



Developn	nent (continued)					
* Childre	en Under Five Only					
Age when	your child first:	Any known development delays? ☐ Yes ☐ No				
Rolled	Walked	If yes, please explain:				
Sat	First Teeth					
Crawled	Toilet trained					
First Word	Talked					
* Childre	en Under Two Only					
Birth Histo	ory:					
Mother's 1s	t, 2nd, 3rd pregnancy:	Method of Delivery: ☐ Vaginal ☐ Caesarian section				
Weeks preg	nant at delivery:	Birth Weight:				
Mothers age	e at patient's birth:	Birth Hospital:				
Fathers age	at patient's birth:	Days in Hospital				
Problems w	ith: ☐ Sleep ☐ Urination	□ Stooling □ Weight □ Height □ Behavior				
Problems de	uring delivery?					
Passed new	born hearing screen? Yes	☐ No Problems in the first month?				
Feeding hist	tory:	☐ Breastmilk ☐ Formula ☐ Both				
Age started	solid food:	Feeding issues or intolerance:				
Special Diet	?					
Please Ex	plain any yes answers:					

Comment	ts/ Concerns/ Extra Sp	ace				