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PEDIATRICS AND ADOLESCENT MEDICINE

Today's Date: _____

Patient's Name: _____ Patient's DOB: _____

Hispanic or latino? (circle): yes no

If no, circle ethnicity(circle):

White Black or African American Native American or American Indian

Asian / Pacific Islander Other: _____

Other siblings seen in this office:(list below)

PATIENT BIRTH HISTORY:

Birth Hospital: _____

Weeks at birth: _____

Vaginal or C-section?: _____

Birth weight: _____

Birth length: _____

Delivery complications with mother or baby?:

NICU stay(circle): yes no

If yes, why and for how long?

PATIENT MEDICAL HISTORY:

Allergies: _____

Medications: _____

Any previous stays in the hospital?
(circle): yes no
If yes, when and why:

Previous surgeries(list below):

FAMILY MEDICAL HISTORY:(list affected family members below)

Bleeding disorder: _____
Cancer: _____
Diabetes: _____
Heart condition: _____
Eye disorder: _____
Ear disorder: _____
Breathing disorder: _____
Digestive disorder: _____
Urinary disorder: _____
Muscle disorder: _____
Brain, spine disorder: _____
Mental health disorder: _____
Skin disease: _____
Other: _____

PATIENT'S MEDICAL HISTORY:

Bleeding disorder: _____
Cancer: _____
Diabetes: _____
Heart condition: _____
Eye disorder: _____
Ear disorder: _____
Breathing disorder: _____
Digestive disorder: _____
Urinary disorder: _____
Muscle disorder: _____
Brain, spine disorder: _____
Mental health disorder: _____
Skin disease: _____
Other: _____

Social History

Do both parents live with patient? (circle):	yes	no
Other than guardians, who else lives with patient? _____		
Does anyone in the house smoke? (circle):	yes	no
Are there any pets at home? (circle):	yes	no
Is patient in daycare or school? (circle)	yes	no
If older than 1 year of age, has patient been to dentist? (circle)	yes	no