Greer Pediatric Center
Medical History

Patient's Name: _____ **Date of Birth:** _____

1. **Current Concerns:**
   - Reason for today's visit: _____
   - Any symptoms or issues: _____
2. **General Health:**
   - Any chronic illnesses or conditions? _____
   - Any hospitalizations or surgeries? _____
   - Any significant injuries? _____
3. **Developmental History:**
   - Any developmental delays or concerns? _____
4. **Allergies:**
   - Drug allergies: _____
   - Food allergies: _____
5. **Medications:**
   - Current medications (name and dosage): _____
   - _____
6. **Immunizations:**
   - Up-to-date with vaccinations? Yes / No / Partially
7. **Family History:**
   - Family members with significant medical conditions (e.g., diabetes, heart disease, Asthma): _____
8. **Psychosocial History:**
   - Any behavioral or emotional concerns? _____
   - Family dynamics or changes affecting the patient: _____
   -
9. **Pregnancy History for this Child:**
   - Did you smoke or Drink alcohol during pregnancy: _____
   - Where was the child born: _____
   - Full Term or Pre-Term: _____
   - Type of Delivery: Vaginal, C-Section Birth Weight: _____
   - Is the Baby Breast fed or Bottle? Formula type: _____
10. **Social History**
    - Does the child attend daycare or School if yes, then where: _____
    - Concerns about behavior or school performance? _____
    - If there are pets in the home, what type: _____
    - Exposure to tobacco smoke? Yes No

Additional Information/Comments:

- _____
- _____

Circle any symptoms that you are experiencing.

General Fever Chills Excessive Sweating	**Skin** Rashes Eczema	**Eyes** Vision Problems Eye Infections
Ears/Nose/Throat Hearing Problems Frequent Ear Infections Nose bleeds Sore Throats	**Breathing** cough Wheezing Shortness of Breath	**Heart/Chest** Heart Murmurs Chest pain blue lips/fingertips
Stomach Vomiting diarrhea Constipation	**Bladder** Frequent urination Bedwetting	**Muscle/Skelaton** Joint Pain Muscle Weakness
Neurological Headaches Seizures	**Psychiatric** Mood Swings Anxiety Depression	**List any other Symptoms**

Signature of Parent/Guardian: _____ Date: _____

Please complete this form accurately to help us provide the best care for your child at Greer Pediatric Center. Thank you for your cooperation!

Greer Pediatric Center

Release of Medical Records

I request that:

Previous Pediatric office/physician: _____

Phone: _____

Fax: _____

Email: _____

Please release the complete medical records including progress notes, nurse notes, labs/x-rays reports, hospital records, immunizations and any referral/consult notes on the following patient from their birth to present:

Patients Full Name: _____ DOB: _____

Please Send Records to:

Greer Pediatric Center
111 Memorial Drive
Greer, SC 29650
Phone: 864-848-7005
Fax: 864-848-3666
Email: Info@gpcmeds.com

Parent/Guardian's Name_____

Signature_____

Date_____