CRESTWOOD PEDIATRICS ASSOCIATES, PC

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PATIENT HISTORY FORM

ACCOUNT: ____________________

Child's Last Name: ____________________ First Name: ____________________

Date of Birth: ____________________ Sex: ___ M ___F Birth Weight ____________________

Father's Name: ____ DOB: ____________________

Mother's Name: ____ DOB: ____________________

Child's Previous Physician: ____

Were there any problems during pregnancy, labor or delivery? ______ YES ______ NO

If yes, please explain: ____

____

Type of Feeding: _______ Breast ________ Formula Type: ____________________

Were there any problems during the first 6 months of life: ____________________

____

Has the child had any chronic or significant past illnesses, surgeries or hospitalizations?

____

____

Current/Chronic Medications: ____

Specialists Following Child: ____

Are there any allergies to any Medications? ____

____

FAMILY MEDICAL HISTORY

Please include child's immediate family: Parents, Grandparents, Brothers, Sisters only:
Circle yes or no, if yes, give relationship, (i.e. Maternal grandmother)

Heart Disease	YES NO	____________________
Tuberculosis	YES NO	____________________
Seizures	YES NO	____________________
Ear/Eye Problems	YES NO	____________________
Mental Retardation	YES NO	____________________
Chest/ Lung Problems	YES NO	____________________
Stomach/Colon Problems	YES NO	____________________
Kidney Problems	YES NO	____________________
Arthritis/Bone/Joint Problems	YES NO	____________________
Diabetes	YES NO	____________________
Cancer	YES NO	____________________
High Blood Pressure	YES NO	____________________
High Cholesterol	YES NO	____________________
Mental Illness	YES NO	____________________
AIDS/HIV	YES NO	____________________

Signature of Parent/Guardian: ______________________________ Date: ____________________