Eureka PEDIATRICS
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Ted Green, M.D. Douglas Nozaki, M.D.

HEALTH HISTORY

Patient's Name_____ **Date of Birth** _____

Pharmacy_____**Location**_____

Has your child ever had any of the following: (If "yes" please explain)

A serious illness or medical condition? _____

A Serious accident or injury? _____

An operation? _____

A frequently recurring illness? _____

A concussion, if so how many? _____

Is your child current on their vaccinations? _____

Current Medications: Please list any medication that the patient is using including over the counter medications, vitamins.

Medications	Dose/Amount	How many times per day

Allergies (food, insects, medications etc.)**:** _____

Reaction: _____

Family Medical History: Please indicate which family member

Seasonal/Food Allergies _____ Asthma_____
High Blood Pressure _____ Cancer_____
Early Heart Disease_____ Eczema_____
High Cholesterol_____ Seizures_____
Hearing Problems_____ Diabetes_____
Headaches/Migraines_____ Kidney Disease_____
Behavioral Problems_____ Family Violence_____