NEW PATIENT MEDICAL HISTORY

DATE____________________

PATIENT____DOB__________________

BIRTH WEIGHT____________________ IF PREMATURE, HOW MANY WEEKS?_________________

ANY PROBLEMS AT BIRTH THAT REQUIRED SPECIAL TREATMENT? YES______NO______

IF YES, PLEASE LIST:____

____

CHRONIC OR RECURRENT ILLNESSES____

____

OPERATIONS/FRACTURES/SERIOUS INJURIES____

____

CURRENT MEDICATIONS____

ALLERGIES:	DRUGS/ANTIBIOTICS	TYPE OF REACTION
	____________________________	________________________________
	____________________________	________________________________
	FOODS/OTHER	TYPE OF REACTION
	____________________________	________________________________

IMMUNIZATIONS – UP TO DATE? (A COPY OF THESE DATES AND SHOTS WILL BE REQUIRED)
_______YES_______NO

AGE OR DATE YOUR CHILD HAD CHICKEN POX__________OR DATE OF SHOT__________

DEVELOPEMENT OR LEARNING PROBLEMS____

____