

**CONFIDENTIAL PEDIATRIC PATIENT INFORMATION**

Date \_\_\_\_\_

Name \_\_\_\_\_  
First, MI, Last

Sex \_\_\_\_\_  
M or F

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo/Day/Year

Age \_\_\_\_\_

Address \_\_\_\_\_  
Include street type such as St., Ave., etc. City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Person Submitting information: \_\_\_\_\_ Relationship: \_\_\_\_\_

**MAJOR COMPLAINT(S), SYMPTOMS, PROBLEMS... (List by priority if more than one):**

1 \_\_\_\_\_ 2 \_\_\_\_\_

3 \_\_\_\_\_ 4 \_\_\_\_\_

5 \_\_\_\_\_

When did the problem(s) first begin? \_\_\_\_\_

Other Doctors seen for the problem(s)? \_\_\_\_\_

Type of treatment: \_\_\_\_\_ Results: \_\_\_\_\_

How often does this problem affect the child? Constant  Daily  Weekly  Monthly  Other \_\_\_\_\_

Since it first began, has the problem... Gotten worse  Gotten better  Persisted/Stayed the same

**Past Medical History:** List all major illnesses, injuries, accidents, all immunizations, surgeries, or hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Birth History:** Indicate location, C-section/Vaginal, forceps, suction, complications, length, medications, mom's age at birth, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diet History:** Include past and current diet, bottle/breast milk, which foods introduced, timing, use of supplements, appetite, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Growth History:** Include birth weight/height, age of standing, walking, talking, etc., sleep patterns, toilet training, habits, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavior History:** Include learning, activities, reaction to discipline, attention, interaction with others, separation response, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Symptoms:** Include respiratory, allergies, asthma, digestive, regurgitation, vomiting, colds, ear infections, etc.

\_\_\_\_\_  
\_\_\_\_\_