DELTA PEDIATRICS



INITIAL PEDIATRIC HEALTH HISTORY

Your child's health is important to us. Please fill out this form as completely and as accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss with you. All information is treated confidentially.

PATIENT INFORMATION

Last		First		Mi	ddle		☐ Fem
Date of Birth: A	ge:	Child's Prior Pedia	atrician:				
Month Day Year							
Preferred Method of Contact (Choose one)	Phone ☐ Email	☐ Mail					
Are there any pets in the home? \Box No \Box Ye		_					
Can we send lab results to your email? \square No \square No some smoke in the home? \square No \square Ye							
GENERAL INFORMATION							
leason for today's visit?							
Ooes your child have any serious illness or							
medical condition?		Explain:					
Has your child had any serious accidents?		Explain:					
Has your child had any surgery?	□ yes □ no	Explain:					
Has you child ever been hospitalized?	□ yes □ no	Explain:					
s your child allergic to any medicines or drugs s your child currently taking any medications	? □ yes □ no	Explain:					
(either prescription or non-prescription)?	□ yes □ no	Explain:					
CHILD'S BIRTH HISTORY							
Firth weight:	Did m	nother have any complic	ations w	ith her			
lbs oz.	pregn	•					
	□ No	☐ Yes, Explain					
		•					
Child born □ Term □ Early □ Late?	Was t	he delivery					
•	Was t □ vag	he delivery inal □ cesarean					
Child born □ Term □ Early □ Late? f early how many weeks gestation?	Was t □ vag	he delivery					
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