Avon Pediatrics Patient Information and Medical History

Name: Soc. Sec #; Who does this child live with: Relationship			Ι	Demographi	ics			
Birthdate: Soc. Sec #: Who does this child live with: Family History Relationship	Name:							
Station Stat	Birthdate:		Soc. Sec #:					
Relationship DOB General Health Father Mother Sibling Sibling	Who does this child	live with	i:			·		
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Sibling Sibl								
Sibling								
Please answer with a check mark if any of the following conditions apply to any member of your family including grandparents, aunts and uncles. Alterby Alcohol Arthritis Asthma Tobacco Heart Attack <50 years old Cancer Thyroid Tuberculosis Diabetes Developmental Delay Cystic Fibrosis Heart Osease Vision Epilepsy Psych Hypertension Frequent Infections Birth History Delivery Hospital: OB: Number of Pregnancies: Full term?: Delivery: Vaginal/C-section Birth Weight: Length: Head Circumference: Mothers Bld Type: Infants Bld Type: Feeding: Condition at Birth: Hearing Screen: Passed/Failed Problems at Birth After birth did your baby have: Jaundice(yellow)? Require Oxygen? How Long? Discharge Date: Discharge Wt.: Past Medical History General Health: Ongoing Medical Problems: Hospitalizations/Surgery(when and what for): Chicken Pox: Smoke Exposure: Alcohol: Injuries: Seizures: Loss of Consciousness Is the patient on any medication? If so, what kind, how much and how often? Completed by: Date: Updated: Initials: Updated: Initials:		•					_	
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Heart Disease	Cancer		Thyroid		Tuberculosis			
Psych Hypertension Frequent Infections	Diabetes		Developmental Delay		Cystic Fibrosis			
Birth History Delivery Hospital: OB: Number of Pregnancies: Full term?: Delivery: Vaginal/C-section Birth Weight: Length: Head Circumference: Mothers Bld Type: Infants Bld Type: Feeding: Condition at Birth: Hearing Screen: Passed/Failed Problems at Birth: After birth did your baby have: Jaundice(yellow)? Require Oxygen? How Long? Discharge Wt.: Past Medical History General Health: Ongoing Medical Problems: Hospitalizations/Surgery(when and what for): Chicken Pox: Smoke Exposure: Alcohol: Injuries: Seizures: Loss of Consciousness Is the patient allergic to any medications? If so, please list the medication and what kind of reaction: Is the patient on any medication? If so, what kind, how much and how often? Completed by: Date: Updated: Initials:	Heart Disease		Vision		Epilepsy			
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