Avon Pediatrics
Patient Information and Medical History

Demographics

Name:_____ Gender:_____
Birthdate:_____ Soc. Sec #:_____
Who does this child live with:_____

Family History

Relationship	DOB	General Health
Father		
Mother		
Sibling		
Sibling		
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.

Allergy	**Alcohol**	**Arthritis**
Asthma	**Tobacco**	**Heart Attack <50 years old**
Cancer	**Thyroid**	**Tuberculosis**
Diabetes	**Developmental Delay**	**Cystic Fibrosis**
Heart Disease	**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 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:_____
Updated:_____ Initials:_____