Family Tree Medical Center™

CONFIDENTIAL PATIENT HEALTH RECORD - PEDIATRIC

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____
Street Apt. #

City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate: ___/___/___ Age: ____

Gender: M / F

GUARDIAN OR PARENT INFORMATION

Name: _____
First Middle Last

Address: _____
(if different from patient information) Street Apt. #

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____ Occupation: _____

Marital Status: ☐ single ☐ partnered ☐ married ☐ divorced ☐ widowed ☐ separated

Social Security #: _____ Partner's Name: _____

Whom may we thank for referring you? _____
(Or how did you hear about us?)

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Name of Pediatrician: _____ Phone: _____

REASON(S) FOR SEEKING CARE

Please list your main health concern(s) *in priority order*:

Problem/Concern/Symptom:	Date of Onset
1st	
2nd	
3rd	
4th	
5th	
6th	
7th	

HEALTH HISTORY

Please check ☑ symptoms you currently have or have had:

- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Birth Defects
- ☐ Bone Fractures
- ☐ Chicken Pox
- ☐ Colic
- ☐ Constipation
- ☐ Cough/Wheeze
- ☐ Cradle Cap
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizzy Spells
- ☐ Eating Disorder
- ☐ Ear Infections
- ☐ Eczema
- ☐ Epilepsy/Seizure
- ☐ Fatigue
- ☐ Frequent Infections
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Fever
- ☐ Hyperactivity
- ☐ Insomnia
- ☐ Jaundice
- ☐ Learning Disorder
- ☐ Measles
- ☐ Moodiness
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rubella
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stuffy Nose
- ☐ Thrush
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Typhoid Fever
- ☐ Vomiting Spells
- ☐ Weight Gain/Loss
- ☐ Other: _____

IMMUNIZATIONS (Please list types, dates given, and any known adverse reactions)

CURRENT MEDICATIONS, VITAMINS, & OTHER SUPPLEMENTS: (Please include dosages)

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES: (Please include dates)

ALLERGIES (drugs, food, or other substances):

PRENATAL/BIRTH/FEEDING HISTORY

Please list any health problems *mother* experienced during pregnancy with this child:

Term of pregnancy (circle one): Full Premature Late Birth Weight:

Any complications with delivery (circle one)? No Yes;

Place of Birth (circle one): Hospital Home Clinic Other:

Feeding (Please ☑ applicable):
Breast Fed: ☐ No ☐ Yes; How long?
Formula: ☐ No ☐ Yes; What type(s): How long?
Age solid foods began: What foods:
Food Intolerances: ☐ No ☐ Yes; (list foods)
Favorite foods:

24-hour Food/Drink Intake (please list yesterday):

SOCIAL HISTORY

Are parents (circle one): Married / Separated / Divorced / Other: _____

Mother's occupation: _____; Full-time / Part-time

Father's occupation: _____; Full-time / Part-time

Guardian: _____; Relationship: _____

Other's residing in home? ☐ No ☐ Yes; _____ Relationship: _____

Daycare? ☐ No ☐ Yes; Where: _____

Siblings? ☐ No ☐ Yes; (please list names, ages, and any health problems below:

_____

_____

_____

_____

_____

FAMILY HISTORY

☐ AIDS/HIV+
☐ Alcoholism
☐ Allergies/hay fever
☐ Arthritis
☐ Asthma
☐ Breast cancer
☐ Cervical cancer
☐ Ovarian cancer
☐ Prostate cancer
☐ Uterine cancer
☐ Other cancer: _____
☐ Diabetes
☐ Eczema
☐ Gout
☐ Heart disease
☐ Hemophilia
☐ High blood pressure
☐ Kidney disease
☐ Loss of height
☐ Mental illness
☐ Migraines
☐ Obesity
☐ Osteoporosis
☐ Psoriasis
☐ Senility
☐ Seizures
☐ Skin problems
☐ Stroke
☐ Suicide
☐ Tuberculosis
☐ Thyroid problems
☐ Ulcer
☐ Other: _____

OTHER INFORMATION

Is there anything else you would like the doctor to know about you/your child?

_____

_____

_____

_____

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