3. Patient Information and Medical History

Patient Name: ________________________________ DOB (MM/DD/YYYY):___________________

Primary Care Physician: _______________________________ PCP Phone: ________________________

ALLERGIES

As far as you know, is your child allergic to any medications? YES _____ NO _______

If YES, which medications, and what kind of reactions has he or she had? ____________________

Any milk or food allergies? ____

HEALTH HISTORY (please check all that apply):

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes mellitus
- ☐ Headache
- ☐ Hearing loss
- ☐ Meningitis
- ☐ Obesity
- ☐ Otitis media
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Strep throat (recurrent)
- ☐ UTI
- ☐ HIV/AIDS
- ☐ Other _______________________________

SURGICAL HISTORY (please check all that apply):

- ☐ Abdominal surgery
- ☐ Appendectomy
- ☐ Ear tubes
- ☐ Meckel's diverticulum
- ☐ Tonsillectomy
- ☐ Umbilical hernia

☐ Eye surgery ☐ VP shunt

☐ Fracture surgery ☐ Lymph node biopsy

☐ Other _________________________

Please tell us about any health conditions marked on the prior list or any other concern's you may have about your child's health:

CURRENT MEDICATIONS: Name Dosage How Often Taking

In signing this form, I am stating that the following information that I have provided is accurate and up-to-date.

Parent Signature: ____

Date: ____________________________