desert foothills
Family Medicine

_____
PATIENT NAME

_____
NAME OF GUARDIAN COMPLETING FORM

PEDIATRIC DATA BASE

PLEASE LIST ALL PEOPLE WHO SHARE HOUSEHOLD:

SOCIAL

FATHER	BIRTH DATE	OCCUPATION	EDUCATION
MOTHER	BIRTH DATE	OCCUPATION	EDUCATION
OTHER	RELATIONSHIP	AGE	
OTHER	RELATIONSHIP	AGE	
OTHER	RELATIONSHIP	AGE	
OTHER	RELATIONSHIP	AGE	
OTHER	RELATIONSHIP	AGE	

PERINATAL

Birth Date:_____ Birth Weight:_____ Birth Length:_____ Birth Place:_____

Were there any birth related problems? (Pregnancy, Delivery, Infancy)

MEDICAL HISTORY

Childhood illnesses and current medical problems (please list date of occurrence or onset)

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Hospitalization (Date, Reason) Surgeries (Date, Reasons)

1) _____ 1) _____
2) _____ 2) _____
3) _____ 3) _____

Medications (Dose, Times per day, Reasons for taking) Allergies to medications Reactions

1) _____ 1) _____
2) _____ 2) _____
3) _____ 3) _____

DEV

Do you have any concerns about your child's: _____ Development _____ Behavior _____ Eating habits
_____ Sleeping patterns _____School Experience _____ Other_____
Please Explain:

FAMILY HISTORY

List child's blood relatives with the following:	
Hypertension	
Heart Disease	
Diabetes	
Seizures	
Asthma	
Kidney Disease	
Obesity	
Mental Illness	
Other	

Immunizations (Enter Date)

DPT _____
OPV _____
MMR _____
Skin Test _____
Other Data _____
_____
_____
_____