ALPHA PEDIATRICS,PA

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PATIENT HISTORY FORM

Be sure to download and save this document to your computer. This form can be filled out on your computer and emailed to alphapedi01@gmail.com or print the form out and bring it to the office filled out. Thank You!

PATIENT HISTORY FORM:

Please fill out as much information as you can *(if you have any questions please ask the nurse)*

Child's Name: ..... Date: ..... Grade In School: .....

Please List Your Child's Medical History *(Specify When Diagnosed)*:

Is your child up to date on immunizations? If not, please explain

Please List Any Surgeries *(Operations)*, Reason For The Surgery, And Date Of Surgery:

Family History *(Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives)*:

If history is unknown please place an "X" here: .....

	Father	Mother	Grandpa Maternal	Maternal Grandma	Paternal Grandpa	Paternal Grandma	Brother	Sister
Cancer (specify)	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure								
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Season Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol/ Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Depression/ Psychiatriac Illiness	☐	☐	☐	☐	☐	☐	☐	☐

IF THERE IS ANY OTHER SIGNIFICANT FAMILY HISTORY PLEASE LIST HERE

Please list any allergies or adverse drug reactions *(drug and type of reaction)*:

CURRENT MEDICATIONS:

Name of Medication	Start Date	Dose	How often taken

Sign: ..... Date: .....