COTSWOLD PEDIATRICS
3030 Randolph Rd, Suite 102 Charlotte, NC 28211
Phone: 704-512-4475, Fax: 704-512-4478

Medical History Form

Name of Child: _____ Birthdate: _____

Name of Parent or Guardian: _____

Address of Parent of Guardian: _____

A. Medical History (To be completed by Parent)

1. Is your child allergic to anything? No_____ Yes_____

If yes, what? _____

2. Is your child currently under a doctor's care? No_____ Yes_____

If yes, for what reason? _____

3. Is your child on any continuous medication? No_____ Yes_____

If yes, what? _____

4. Any previous hospitalizations or operations? No_____ Yes_____

If yes, when and for what? _____

5. Any history of significant previous diseases or recurrent illness? No_____ Yes_____

Diabetes No_____Yes_____ Convulsions No_____ Yes_____ Heart Trouble No_____ Yes_____

Asthma No_____ Yes_____

If others, what/when? _____

6. Does the child have any physical disabilities: No_____ Yes_____

If yes, please describe:_____

7. Any mental disabilities? No_____ Yes_____

If yes, please describe:_____

** Signature of Parent or Guardian_____ Date_____

B. Physical Examination (To be completed by your Healthcare Provider)

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), or a certified nurse practitioner.

Height _____ Weight _____ BP _____/_____ (if age appropriate)

	Normal	Abnormal	If abnormal, please explain
Head	/	/	
Eyes	/	/	
Ears	/	/	
Nose	/	/	
Teeth	/	/	
Throat	/	/	
Neck	/	/	
Heart	/	/	
Chest	/	/	
Abd/GU	/	/	
Ext	/	/	
Neurological	/	/	
Skin	/	/	
Vision	/	/	
Hearing	/	/	

Developmental Evaluation: Delayed _____ Age Appropriate_____
If delay, note significance and special care needed: _____

_____

Results of Tuberculin Test, if given: Type _____ Date_____ Normal _____Abnormal _____

Should activities be limited? No_____ Yes_____ If yes, explain:_____
Any other recommendations:

_____

_____

Date of Examination: _____

Signature of authorized examiner/title: _____ Phone: _____

Immunization Record: See Attached Sheet