Welcome to the Family Practice Center! Please complete the following

Child's Name _____ Date of Birth _____

Grade in School _____ Name of School _____

Who was your child's previous physician? _____

Why is your child coming to the doctor today? _____

_____

What was your child's birth weight? ____lbs. _____oz. Where there any problem during pregnancy? _____

If so, what? _____

How many days after birth did he/she go home? _____

Has your child had any of the following problems?

PROBLEM	NO	YES	IF SO, WHEN & WHERE?
Chicken Pox			
Ear Infections			
Pneumonia			
Asthma			
Heart Murmur			
Anemia			
Broken Bones			
Kidney (Bladder infection)			
Seizures (convulsions)			
Allergies to medication			
Other problems			

Is there a history of diseases in this child's family? (Mother or Father's)

_____

If so, what? _____

List any and all medications that your child takes (Prescription and non-prescription) _____

_____

Is the child up to date on immunizations? _____

List all previous surgeries _____

_____

Emergency Contact Person

Name _____ Relationship to Patient _____

Address _____ Phone Number _____