Pediatric Pre-Exam Information

Patient:_____ Case#_____ Date_____

Date of Birth_____ Sex_____

Address_____ City_____ State_____ Zip_____

Phone#_____

Mother:_____ Case# if a patient here:_____

Address_____ City_____ State_____ Zip_____

Home Phone#_____ Work Phone#_____

Occupation and Employer_____

Father:_____ Case# if a patient here:_____

Address_____ City_____ State_____ Zip_____

Home Phone#_____ Work Phone#_____

Occupation and Employer_____

Guardian, Sitter, Day Care or School:_____

Address_____ City_____ State_____ Zip_____

Phone#_____

Siblings:

Name_____ Age_____ Sex_____

Name_____ Age_____ Sex_____

Name_____ Age_____ Sex_____

Name_____ Age_____ Sex_____

Native Language_____

Who is responsible for the patient's bill? You___ Spouse___ Auto Insurance_____

Personal Health Insurance_____ Personal Injury_____

Family Health History

Please check this list to see if any blood relatives to the patient had or do have any of the following conditions. If so, please mark next to each condition accordingly: M (Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); MGM (Maternal Grandmother); PGF; or MGF.

Allegy	_____	Kidney Disease	_____
Asthma	_____	Migraine Headaches	_____
Eczema	_____	Liver Disease	_____
Cancer	_____	Mental Retardation	_____
Diabetes or Low Blood Sugar	_____	Mental Illness/Nervous Disorders	_____
Heart Trouble	_____	Scoliosis	_____
High Blood Pressure/Stroke	_____	Ulcers	_____

Other:_____ Please explain:_____

Please Check If Any Of These Items Applied To The Patient At Birth:

Medication _____
Surgery _____
Artificial Feeding _____
Silver Nitrate _____
Vitamin K _____
Circumcision _____
Other _____ Please Explain:_____

Nutrition

Please check if the patient has received any of the following:

Breast Milk _____
Formula _____ Brand(s):_____
Cow's Milk _____ Goat's Milk _____
Soy Milk _____ Sweets _____
Juice: Fruit _____ Juice: Vegetable _____
Vitamins/Supplements_____ Brand(s) or type(s):_____
Solid Foods _____
If yes, when were they started and what was first introduced?_____
Medications _____Please list:_____
Other _____Please explain:_____

Previous Health Care

Name of Pediatrician: _____ Chiropractor:_____
Date of last exam:_____

Please list any conditions or illnesses that have already been diagnosed. Include any serious mental or physical traumas for which treatment was recommended and/or received:

Please list the immunizations the patients has received and any reactions observed:

Date	Immunization(s)	Reactions

Note foreign travel:

Please list any falls, spills, or accidents, etc. not noted previously:

Please write any other information about the patient that you feel may be helpful: