Partners in Pediatrics
NATURALLY HEALTHY KIDS

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NEW PATIENT MEDICAL HISTORY

DATE _____/_____/_____

PATIENT _____ DATE OF BIRTH _____/_____/_____

BIRTH WEIGHT _____ IF PREMATURE, HOW MANY WEEKS? _____

ANY PROBLEMS AT BIRTH THAT REQUIRED SPECIAL TREATMENT? YES _____ NO _____

IF YES, PLEASE LIST: _____

_____

CHRONIC OR RECURRENT ILLNESSES _____

_____

OPERATIONS/FRACTURES/SERIOUS INJURIES _____

_____

CURRENT MEDICATIONS: _____

ALLERGIES:	DRUGS/ANTIBIOTICS	TYPE OF REACTION
	_____	_____
	_____	_____
	_____	_____
	FOODS/OTHER	TYPE OF REACTION
	_____	_____
	_____	_____

IMMUNIZATIONS:

UP TO DATE? (A COPY OF THE SHOTS AND THE DATES THEY WERE ADMINISTERED WILL BE REQUIRED)

AGE AND DATE YOUR CHILD HAD CHICKEN POX _____ OR DATE OF SHOT _____

DEVELOPMENT OR LEARNING PROBLEMS _____

_____

_____