Moon Valley Pediatrics

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Phone: 602-298-6930 Fax: 602-298-6918

PATIENT HISTORY

CHILD'S NAME _____ **DOB** _____

Form completed by: _____ **Relationship to the child:** _____

BIRTH HISTORY

Birth Weight _____ Length _____ Place of Birth _____
Preterm or Full Term _____ Vaginal or C-section delivery _____
Any complications during pregnancy or delivery? _____
How long did the baby stay in the hospital after birth? _____
Did he/she have any problems? (i.e. Jaundice, respiratory distress, infection) _____

PAST MEDICAL HISTORY

Has the child ever had any problems with the following? If YES, please explain:

ADHD	YES_____ NO_____
Asthma/RAD	YES_____ NO_____
Allergies (food/environmental)	YES_____ NO_____
Anemia/Blood Disorders	YES_____ NO_____
Bones/Joints	YES_____ NO_____
Diabetes	YES_____ NO_____
Ears (multiple infections)/Hearing	YES_____ NO_____
Eyes/Vision	YES_____ NO_____
Gastrointestinal (GE reflux/Constipation/diarrhea)	YES_____ NO_____
Heart	YES_____ NO_____
Repeated infections	YES_____ NO_____
Seizures/Headaches	YES_____ NO_____
Skin (eczema)	YES_____ NO_____
Urine/Kidneys	YES_____ NO_____

Other _____

Allergies to medicine YES_____ NO_____

Please list any hospitalizations, operations, serious illness or injuries with dates:

_____ Date: _____
_____ Date: _____

Please list any developmental problems or delays and when they occurred:

_____ Age: _____
_____ Age: _____

Immunizations up to date? YES_____ NO_____

Please list medications child is currently taking and reason:

Medication	Reason
_____	_____
_____	_____
_____	_____