

PATIENT HISTORY RECORD

Patient Name: _____ Date of Birth: ____/____/____

BIRTH HISTORY

Birth weight: ____ lbs. ____ oz. Length: ____ inches Hospital: _____

Obstetrician: _____ Delivery: Vaginal C-Section

Problems/Complications (i.e.: jaundice, breathing problems, etc.): _____

Medications Needed: _____

Breast Fed Bottle Fed Formula: _____

FAMILY HISTORY

Paternal: Diabetes Heart Disease Hypertension Asthma Eczema Allergies Cancer

Other: _____

Maternal: Diabetes Heart Disease Hypertension Asthma Eczema Allergies Cancer

Other: _____

SOCIAL HISTORY

(i.e.: jaundice, breathing problems, etc.)

ALLERGIES

Medications: _____

Other: _____

Date Tested: _____

HOSPITALIZATIONS &/OR OPERATIONS

FAMILY

Dad's Name: _____ Health Status: Good Fair Poor

Mom's Name: _____ Health Status: Good Fair Poor

Siblings

Name: _____ FULL HALF STEP Health Status: Good Fair Poor

Name: _____ FULL HALF STEP Health Status: Good Fair Poor

Name: _____ FULL HALF STEP Health Status: Good Fair Poor

PROVIDER'S INITIALS _____