Patient Name: _____ Date: _____

Current Medications

Please list all medications you are taking at this time, include vitamins, topicals, injections, supplements & herbals or provide a complete list. (use back if needed.)

Name of Drug	*Dose (include strength and number of pills per day)*	*How long have you taken this medication?*	*Why do you take this medication?*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PHARMACY _____

Allergies - Please list all medications and environmental agents you are allergic to. Please include what type of reaction you have (hives, nausea, breathing problems, etc.) and severity.

Past Medical History - Please include all medical problems such as diabetes, hypertension, etc.

Past Surgical History - Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc. Include year completed

Family History - Please list all major medical conditions.

Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Specify grandmother as GM grandfather as GF
Maternal Grandparent _____
Paternal Grandparent _____
Other _____

Social history:

Passive Smoke exposure: yes/ no

Child Lives with (circle all that apply): Mom Dad Step parent sibling grandparent
Other: _____
Number of Siblings: _____
Does the child participate in any sports or extracurricular activities: Yes/ No
Type: _____
Length: Seasonal/ year long
If applicable, how many times per week?: _____
Do you own any animals or pets?: _____
Primary care physician or pediatrician: _____
Specialists: _____