MEDICAL HISTORY FORM – PEDIATRIC PATIENTS

Date: _____

Patient Name:_____ DOB: _____ Age: _____

Sex: Male _____ or Female _____ Height: _____ Weight:_____

Reason for today's visit: _____

How long have you had this problem? _____

Is the problem due to an accident?_____ Date of Injury: _____

Type of Accident: _____

Please list any prior hospitalizations and/or surgical procedures: _____

_____

Do you have any allergies to medications?_____

Are you currently taking any medications? _____ If yes, please list:

_____