Healthy Days
PEDIATRICS

Dr. Alison Days

NEW PATIENT MEDICAL HISTORY

DATE_____

PATIENT_____ DOB_____

PARENT NAME_____

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
_____	_____

IMMUNIZATION - UP TO DATE? (A COPY OF THESE DATES AND SHOTS WILL BE REQUIRED)

_____ YES _____NO

AGE OR DATE YOUR CHILD HAD CHICKEN POX _____ OR DATE OF SHOT_____

DEVELOPMENT OR LEARNING PROBLEMS_____

_____

HAS YOUR CHILD BEEN SEEN BY A DENTIST? ❑YES ❑NO DATE OF LAST VISIT_____