SILVERLAKE PEDIATRIC CLINIC

MEDICAL HISTORY FORM

Date: ____________________

Patient's Name: ____________________

Date Of Birth: ___ / ___ / ___ Age: ________ Sex: M / F

Previous Physician's name: ____________________

Office Phone Number: ____________________ Fax Number: ____________________

Statement of Patent's Current Health and Medications Currently Used

Allergies(Include Medication , insect bits/stings and common foods) :

Medication	Food/Substance	Insect Bites

Current Medication : List the medications you are currently taking, also list any Vitamins, Herb, Etc.

Medication Name	Dosage

Birth History : Vaginal Delivery ______ C-SectionIDelivery ______

Developmental History : ☐ Sitting At ______ Month ☐ Talking Few Words At ______ Month

☐ Walking At ______ Month ☐ Climbing At ______ Month

Chickenpox ☐ Yes, Date: ____________________ ☐ No

Hospitalization: ____________________

Surgery: ____________________

Chronic Illness: ____________________

Family History: Check the Illness that have occurred in your immediate family

	ASTHMA		CHEST PAIN		HYPERTENSION
	ADD /ADHD		CONSTIPATION		HEART ATTACH
	ALLERGY		CONVULSION		HIV
	ANEMIA		DEPRESSION		KIDNEY DISORDER
	BED WETTING		DIABETES		LEARNING DISORDER
	BIPOLAR DISORDER		DIZZINESS		MENTAL DISORDER
	BLEEDING DISORDER		DOWN'S SYNDROME		RECENT TONSILLITIS
	CARDIAC ARTHEMIA		FAINTING		STROKE
	CANCER		ECZEMA		SICKEL CELL DISEASE
	LEARNING DISORDER		THYROID DISORDER		TUBERCULOSIS
	SUDDEN DEATH AT EARLY AGE		VESICO URETHRAL REFLUX		

The above information is true to the best of my knowledge.

Patient/Responsible Party Signature ____________________ Date