PREMIER pediatrics

PATIENT HISTORY FORM

Patient's Name: _____ **DOB:** _____

Birth History

Was this child O Full Term O Preterm O Adopted (at what age?) _____
How many weeks at delivery? _____
Birth Weight: _____ Length: _____
Type of delivery: O Vaginal O C-section Reason for C-section _____ NICU stay: O Yes O No
Did he/she have any problems in the newborn period? _____

Past Medical History

Please check any illnesses your child has had

O Anemia	O Heart Murmur	O Seizures	O Allergies
O Asthma	O Pneumonia _____ (date)	O Eczema	O Reflux (GERD)
O Chicken Pox _____ (date)	O RSV/Bronchiolitis/Bronchitis	O Urinary infection	O ADD/ADHD
O Recurrent ear infections	O Recurrent throat infections	O Other: _____	

List any surgeries/hospitalizations & dates: _____
List any known allergies: _____
List all medications taken on a regular basis: _____

Family History

Please indicate what family member has the following: Mother(M), Father(F), Brother(B), Sister(S), maternal grandmother(MGM), maternal grandfather(MGF), maternal aunt(MA), maternal uncle(MU), paternal grandmother(PGM), paternal grandfather(PGF), paternal aunt(PA), paternal uncle(PU)

Anemia	Allergies	Asthma	Bleeding disorder
Bipolar	Cancer	Crohn's disease	Diabetes
Eczema	Emotional problems	Epilepsy	Heart Attack
High blood pressure	High cholesterol	Kidney Disease	Lazy Eye
Lupus	Migraines	Pneumonia	Renal disease
Sickle Cell Trait/Diease	Stroke	Thyroid disease	Tuberculosis
Ulcerative Colitis	Unexplained/Sudden Death	HIV/AIDS	Urinary Reflux

Other conditions not listed _____

Is there anything more you would like us to know about your child? _____

_____

I voluntarily authorize and consent to the child listed below to receive medical care, treatment, vaccines, and diagnostic tests that is deemed necessary by the clinicians and healthcare personnel at Premier Pediatrics of Houston, PLLC while he/she is a patient in this office or until I withdraw my consent. By signing below, I verify that I have the legal right to consent for the patient listed below and that I have read (or they were read to me in a language that I understand) and I agree to follow the policies set forth in the No Show Policy, Immunization Policy, Financial Policy, and Privacy Practices.

Patient Name: _____Patient's DOB: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____