

Mendon Pediatrics

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Child's Name: _____ Date of Birth ___/___/___

Medications: _____

Allergic Reactions:

Medications: _____

Food: _____

Animals: _____

Insect Bites: _____

Hospitalizations or surgeries: Where, When and Why:

Past Medical History:

Has the child had any of the following diseases? Check all that apply.

____ Chicken Pox. If yes, When? _____

____ Recurrent Infections (ear or throat)

____ Asthma

____ Allergies

____ Seizures

____ Bleeding Problems

____ Anemia

____ Hepatitis

____ Serious Injuries

____ Hearing Problems

____ Vision Problems

____ Other

If answered yes to any of the above, please explain:

Pregnancy and Birth: _____

Birth wt. _____

Birth ht. _____

Type of delivery: _____

Comments: _____

Formula: _____