

GABRIEL PEDIATRICS, PC

PATIENT NAME _____ DATE OF BIRTH _____

BIRTH HISTORY:

Gestational Age _____ Birth weight _____ Birth length _____ Birth Hospital _____

Complications: _____

HOSPITALIZATION:

Where: _____ Date: _____ Reason: _____

Where: _____ Date: _____ Reason: _____

Where: _____ Date: _____ Reason: _____

ALLERGIES (please check specific type of allergy, as well as indicating name and reaction): None

Drug Environmental or Food Allergen Name: _____ Reaction: _____

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FAMILY HISTORY (please check all that apply and indicate relation to patient):

Anemia Relation: _____ Allergies Relation: _____

Asthma Relation: _____ Alcohol Abuse Relation: _____

Cancer Relation: _____ Drug Abuse Relation: _____

Diabetes Relation: _____ High Cholesterol Relation: _____

High Blood Pressure Relation: _____ Seizures Relation: _____

Stroke Relation: _____ Thyroid Relation: _____

Tuberculosis Relation: _____ Heart Disease- before 50 yrs old Relation: _____

Other _____ Relation: _____

PAST HISTORY (please check all that apply):

Chickenpox When: _____

Frequent ear infections Explain: _____

Problems with ears or hearing Explain: _____

Problems with eyes or vision Explain: _____

Asthma, bronchitis, bronchiolitis, or pneumonia Explain: _____

Any heart problem or heart murmur Explain: _____

Anemia or bleeding problem Explain: _____

Frequent abdominal pain Explain: _____

Bladder or kidney infection Explain: _____

Any chronic or recurrent skin problem (acne, eczema, etc) Explain: _____

Frequent headaches Explain: _____

Seizures or other neurological problem Explain: _____

Thyroid or other endocrine problem Explain: _____

Any other significant problem Explain: _____