GEORGETOWN PEDIATRICS. P.C,

Existing Patient Medical History

Patient Name: _____ DOB_____ AGE_____

Please fill in the appropriate column if either the patient or the family member has had a history of any of the following medical problems since last UPDATED: Reviewed by:_____ Date_____

Medical Diagnosis	**Y** ✓	**N** ✓	**Patient** (Age of Diagnosis)	**Family** (Member and *Age of Diagnosis)*
Addictions (drug, alcohol, tobacco)				
Anemia or Bleeding Disorders				
Asthma, breathing problems				
Behavioral, psychological				
Cancer				
Chronic Skin Disorders				
Cystic Fibrosis				
Deafness or Hearing Disorder				
Diabetes				
Digestive Disorders				
Fracture or Bone/Joint Disorder				
Frequent or severe infections				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Learning Disorders				
Liver Disease				
Mental Retardation				
Migraine				
Seizures				
Significant Heart Murmur				
Thyroid Disease				
Tuberculosis				
Unexplained Death				
Urinary Tract Infections				
Visual Disturbances				

Any current known allergies to the following? (Environment, Food, Medicine) (Y)(N) Please List below		
Environment:	Food:	Medicine:
Any medications currently or frequently used: (Y) (N) if yes, please list below		
Name:	Dosage:	Frequency:
Name:	Dosage:	Frequency:

Please list any other problems or concerns the doctor should be aware of:

_____

Parent or Guardian Signature _____ **Date** _____