Children's Medical Information Sheet

Child's Name ____ Birth date __________ Age _____

Reason for Visit ____ Date ___________

Allergies to Medications ____

Other Allergies ____

Current Medications ____

____

Over the counter meds ____

Other doctors you currently see ____

Past Medical History (for this child only)

Surgeries (dates) ____

Hospitalizations ____

Does **this child** have any of the following? (now or in the past)

Asthma	Chronic coughing	Allergies	Sinus infections
Diabetes	High blood pressure	Ear infections	Seizures/convulsions
Rashes	Reflux (spitting up)	Wetting the bed	Loss of consciousness
Food allergies	Trouble sleeping	Anemia	Scoliosis/crooked spine

Details:

____

____

Immunizations: check each disease and date of last immunization

Hepatitis B ________	Hepatitis A ________	Pneumonia ________	HIB ________
Influenza ________	Tetanus ________	Chicken pox ________	MMR ________

Family Medical History

Cancer	Diabetes	Heart disease	High blood pressure
Depression	Stroke	High cholesterol	Asthma / Emphysema

Details: ____

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Signed (parent) ____ Reviewed by __________

Bedford Family Medicine, PA **Confidential- Do Not Copy**