FACE SHEET

CHRONIC MEDICAL CONDITIONS

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DRUG ALLERGIES

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Patient's Name ____ DOB ___________ Date First Seen ______________

Sex: ☐ M ☐ F Home Phone No. ______________________________

Father's Name ____ Father's Work Phone No. ______________________

Father's DOB ____________ Living? ☐ YES ☐ NO Mother's Work Phone No. ______________________

Mother's Name ____ Other Phone No. ______________________________

Mother's DOB ____________ Living? ☐ YES ☐ NO

Guardian (if not parents) __________________________________ Parents' Marital Status ________________________

Home Address (street, city, state, zip) ____

MATERNAL & NEWBORN HISTORY (check problem areas)

Pregnancy: ☐ Excessive weight gain, swelling ☐ Toxemia ☐ Venereal disease
☐ Hypertension ☐ Urinary tract infection ☐ Diabetes
☐ Other ____

Birth: Delivery: ☐ Vaginal ☐ Cesarean Section Birth Weight: ______________________
Baby was: ☐ Full Term ☐ Premature _______ weeks Apgar Score: ______________________
Problems after birth: ____
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Newborn: ☐ Breast ☐ Formula ______________________________
☐ Feeding problems ☐ Multiple formula changes ☐ Recurrent vomiting ☐ Poor weight gain
☐ Colic ☐ Blood in stool ☐ Recurrent diarrhea ☐ Jaundice
☐ Other ____

PAST MEDICAL HISTORY (check if patient has history of)

☐ Allergies (environmental) ☐ Frequent Strep throats ☐ Recurrent vomiting
☐ Asthma ☐ Pneumonia, bronchitis ☐ Recurrent diarrhea
☐ Eczema ☐ Heart disease ☐ Recurrent constipation
☐ Frequent respiratory infections ☐ Heart murmur ☐ Chronic anemia
☐ Frequent ear infections ☐ Chickenpox ☐ Seizures
☐ Other: ____________________ ☐ Surgery: ____________ ☐ Hospitalizations: ________________
☐ Developmental Problems: ____

Details of illnesses checked off: ____
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OTHER FAMILY MEMBERS

	SEX	NAME	DOB	LIVING?		DOB	LIVING?	CAUSE OF DEMISE
Father					PGFather			
Mother					PGMother			
Sibling					MGFather			
Sibling					MGMother			
Sibling								
Sibling								

FAMILY HISTORY Check if a member of the ***patient's*** family [father (F), mother (M), sibling (S), maternal grandparent (MGF or MGM), paternal grandparent (PGF or PGM), maternal aunt or uncle (MA or MU),or paternal aunt or uncle (PA or PU) have had the following diseases or problems. *Place the appropriate initial in the blank after each*

☐ Allergies (environmental) ________ ☐ GI disorders ________ ☐ Neuromuscular disease ________
☐ Asthma ________ ☐ Diabetes ________ ☐ Seizures ________
☐ Eczema ________ ☐ Growth problems ________ ☐ Cancer ________
☐ Frequent ear infections ________ ☐ Anemia/Bleeding disorders ________ ☐ Hereditary problems ________
☐ Congenital deafness ________ ☐ High cholesterol ________ ☐ Emotional problems ________
☐ Congenital blindness ________ ☐ High blood pressure/stroke ________ ☐ Substance abuse ________
☐ Lazy eye/amblyopia ________ ☐ Heart attack ________ ☐ Smoking ________
☐ Thyroid disorders ________ ☐ Collagen vascular disease ________ ☐ Other ________