

FACE SHEET

CHRONIC MEDICAL CONDITIONS

DRUG ALLERGIES

Patient's Name _____

Sex: M F

Father's Name _____

Father's DOB _____ Living? YES NO

Mother's Name _____

Mother's DOB _____ Living? YES NO

Guardian (if not parents) _____

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

DOB _____ Date First Seen _____

Home Phone No. _____

Father's Work Phone No. _____

Mother's Work Phone No. _____

Other Phone No. _____

Parents' Marital Status _____

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: _____

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: _____

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*

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