Children's Medical Group, P.C.

Patient's Name ______________________________ **Date of Birth** ______________

Birth Information	
How many weeks gestation?	
Condition at birth: normal good fair	
Birth weight:	length:
Type of delivery: vaginal C-section	
Problems at birth:	

Family History			
Mother's age:		**Circle**	
Father's age:		**Yes** –	**No**
Sibling(s) ages:	**Any history of:**		
	Cancer	yes	no
	Heart disease	yes	no
	Diabetes	yes	no
	Kidney disease	yes	no
	High blood pressure	yes	no
	Mental illness	yes	no
	Seizures	yes	no
	Blood disorder	yes	no
	Other:		
Does anyone in the household smoke? yes no			

Child's History		
Chicken Pox? yes no	What year?	Vaccine? yes no
Surgeries:		
Allergies:		
Other Illnesses:		

REORDER # 04-08802-30