SouthPark Pediatrics, PA

Chart No._____

Patient name(last)_____(first)_____ _____(mid)_____ _____

Nickname_____DOB_____ Sex_____Age_____SSN_____-_____-_____
Mom's first last **Dad's** first last
Name_____Name_____single/married/separated/divorced
E-mail address_____Patient's cell_____
Mom's address_____
Dad's address_____
Mom's phone(H)_____(W)_____(Cell)_____
Dad's phone (H)_____(W)_____(Cell)_____
Emergency contact: Name/Number_____

Birth History: Vaginal ___ C-section___Weeks gestation___Pregnancy number___
Birth weight_____Birth Length_____Discharge weight_____APGAR_____
Complications/breech,etc._____

Past Medical History:Immunization reactions_____DRUG ALLERGIES_____
Developmental concerns_____
Recurrent/Chronic medical problems_____
Allergies__Asthma/bronchitis__Infections-ear__urinary tract__lung__Seizures_____
Specialist referrals_____
Hospitalizations_____
Surgeries_____

Family History:Mom:Ethnic origin_____Religion_____Language_____
Dad:Ethnic origin_____Religion_____Language_____
Mother's DOB_____Occupation_____Health problems_____
Father's DOB_____Occupation_____ Health problems_____
Siblings 1. Name_____DOB_____Health problems_____
2. Name_____DOB_____Health problems_____
3. Name_____DOB_____Health problems_____
4. Name_____DOB_____Health problems_____

Family History-Patient's siblings, parents, grandparents with the following? Yes/No

AIDS/HIV/Sexually transmitted disease	Y/N	Childhood deaths	Y/N	Mental retardation	Y/N
Asthma	Y/N	Diabetes	Y/N	Migraine	Y/N
Allergies	Y/N	Depression	Y/N	Muscular dystrophy	Y/N
Attention Deficit Disorder	Y/N	Eating disorder	Y/N	Obesity	Y/N
Anemia	Y/N	Eczema	Y/N	Pregnancy loss	Y/N
Birth defects/genetic disorder	Y/N	Heart disease/(<55 yrs old)	Y/N	Seizures	Y/N
Bleeding/blood problems	Y/N	Hi blood pressure	Y/N	Stroke(<55yrs old)	Y/N
Cancer/Type_____	Y/N	High cholesterol	Y/N	Vision Problems	Y/N
Crohn's Disease/Inflammatory Bowel Disease	Y/N	Learning disorder	Y/N	Sickle cell disease	Y/N
		Kidney disease	Y/N		
Cystic Fibrosis	Y/N	Scoliosis	Y/N		
Congenital hip disease	Y/N	Childhood arthritis	Y/N		

Social History-Exposure: **Smoke Y/N Pets _____Y/N Day care Y/N**

Completed by_____Date_____

Referred by_____

Reviewed by_____Date_____