



Rock Hill Pediatric Associates

Date _____ Drug allergy _____
 Name _____ Name called _____
 Father's name _____ Occupation _____
 Mother's maiden name _____ Occupation _____
 Address _____ Home phone _____
 Date of birth _____ Sex _____ Race _____ Work phone-mother _____
 Referred by _____ Work phone-father _____

FAMILY HISTORY

Who lives in household with patient _____
 Parents/ages _____ Siblings/sex/ages _____
 Diseases or illnesses: Diabetes _____ Heart disease _____ Hypertension _____
 Allergies _____ Migraine _____ High chol. _____ Seizures _____
 Deaths (immediate family) _____

BIRTH AND DEVELOPMENT

Birth weight _____ Type of delivery _____
 Complications (cyanosis, convulsions, jaundice, etc.) _____

 Feedings _____

ILLNESSES

Previous illnesses and hospitalizations _____

 Operations _____
 Injuries _____

PROBLEMS AND HOSPITALIZATIONS

DATE	REASON
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	