

PATIENT

First name _____ MI _____ Last _____

Date of birth _____

ALLERGIES & MEDICATIONS

Drug allergies? ☐ No ☐ Yes Detail _____

Food allergies? ☐ No ☐ Yes Detail _____

Past surgical history? ☐ No ☐ Yes Procedures & dates _____

Current medications (including dose) _____

MEDICAL HISTORY

Please check all current and past medical issues that apply, and add detail below.

- | | | |
|--|--|---|
| ☐ Asthma | ☐ Allergy | ☐ Eczema |
| ☐ Frequent ear infections | ☐ Sinus infections | ☐ Frequent strep |
| ☐ Heart disease | ☐ Seizures | ☐ Migraine |
| ☐ Diabetes | ☐ Arthritis | ☐ Celiac disease |
| ☐ Thyroid issues | ☐ Growth issues | ☐ Inflammatory bowel disease |
| ☐ Bleeding disorder | ☐ Clotting disorder | ☐ Cystic fibrosis |
| ☐ Learning disability | ☐ Autism / Asperger's | ☐ Depression |
| ☐ Anxiety | ☐ ADD / ADHD | ☐ Other mental illness |

Details _____

OTHER PAST MEDICAL HISTORY

- | | | |
|----------|----------------------------------|-----------------------------------|
| #1 _____ | ☐ Current | ☐ Resolved |
| #2 _____ | ☐ Current | ☐ Resolved |
| #3 _____ | ☐ Current | ☐ Resolved |
| #4 _____ | ☐ Current | ☐ Resolved |

Thank you for helping us care for your child. Giombetti & Brady Pediatrics, PLLC