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Cook's Physician Network

Patient Data History Form

CHILD'S NAME: _____ AGE _____ DATE FILLED OUT _____

BIRTH HISTORY: (Fill out if <3 yr. old)

1. Birthplace: _____
2. Birthdate: _____
3. Birth Weight: _____
4. Birth Length: _____
5. Pregnancy problems? _____
6. Delivery problems? _____
7. Baby full term? _____
8. Nursery problems? _____

FAMILY HISTORY

1. Health of Father? _____
2. of Mother? _____
3. # and health of siblings _____
4. Family Diabetes? _____
5. Family allergies? _____
6. Family convulsions? _____
7. Family high cholesterol? _____
8. Family Tb? _____

GROWTH AND DEVELOPMENT

1. Concerns of weight gain? _____
2. Concerns of height? _____
3. Behind in development? _____
4. School problems? _____
5. Sees counselor? _____

MEDICAL HISTORY

1. Problems sleeping? _____
2. Problems eating? _____
3. In bed with bottle? _____
4. Special diets? _____
5. Taking vitamins? _____
6. Taking fluoride? _____
7. Had Chickenpox? _____

Any problems with:

-- Ears: _____
-- Sinuses: _____
-- Throat: _____
-- Lungs: _____
-- Heart: _____
-- Kidneys/bladder: _____
-- Bones/joints: _____
--Skin: _____
-- Blood: _____
-- Seizures: _____

HOSPITALIZATIONS?

_____

SURGERY?

_____

ALLERGY REACTIONS?

Medications: _____
Insects: _____
Hives: _____

Comments about above medical information: _____

_____

_____

_____

_____

ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

_____

_____

_____

YOUR LAST DOCTOR WAS: _____

WHO REFERRED YOU? _____