Joshi Pediatrics
Patient/Family History Form

Date_____

Name_____ DOB_____ SEX M or F
Updated: _____ _____ _____ _____ _____

Patient History

Is your child allergic to any medication? No Yes, please list:

To your knowledge, is your child up to date on immunizations? No Yes

Does your child take any daily medication(s)? No Yes, please list:

Has your child had any surgeries or hospitalization? No Yes, please list:

Has your child ever had Chicken Pox? If yes, when? No Yes _____

Who was your child's previous physician? None Dr._____

Does anyone who lives with your child smoke? If yes, who? □ No □ Yes _____

Is your child exposed to cigarette smoke on a regular basis? □ No □ Yes

Has your child had any of the following conditions:

Frequent Ear Infections	No	Yes	Eczema/Dry skin	No	Yes
Frequent Sore Throats	No	Yes	Bedwetting	No	Yes
Frequent Sinus Problems	No	Yes	Constipation	No	Yes
Behavior Issues	No	Yes	Diabetes	No	Yes
School Concerns	No	Yes	Anemia	No	Yes
Immune Problems	No	Yes	Heart Murmur	No	Yes
Asthma	No	Yes	Other Disease	No	Yes

Father and Mother Family History

Asthma	No	Yes	Immune Disorders	No	Yes
High Blood Pressure	No	Yes	Seizures	No	Yes
Bleeding Disorders	No	Yes	Kidney Disease:	No	Yes
Diabetes	No	Yes	Kidney Cysts	No	Yes
Anemia	No	Yes	Kidney Stones	No	Yes
Thyroid Disease	No	Yes	Cancer: Type_____	No	Yes

Prenatal History (Mother)

# of live births _____
# of children _____
Miscarriages _____
Any pregnancy complications?

For Nurses Only
*High Risk: Y or N
*Child Health History:
1.) Diabetes: Y or N
2.) HTN: Y or N
3.) BMI>95th %: Y or N
*Family Hx CVD: Y or N
*Parent chol. > 240 or on meds: Y or N
*MI <55 males/<65females: Y or N

Names of child's Siblings/DOB

Are they patients of our practice? Y or N

Parent Signature _____ Date