PEDIATRIC HEALTHCARE ASSOCIATES OF WAXAHACHIE

Patient Medical History and Information Sheet

Name: _____ DOB: _____
Allergies: _____

LIST ALL CURRENT MEDICATIONS **LIST ALL SURGERIES**

Name of Medication Dosage	Surgery Date of Procedure
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.

Has your child had all the immunizations necessary for his or her age? ___ yes ___ no

Has your child ever been hospitalized for medical (nonsurgical) problem? If so list below

_____

_____

Please list previous diagnosis from any other physician?

_____

_____

Social History:
Child Lives with _____ Parents: Divorced Married Foster Single
Siblings' # _____ Boys _____ Girls

Notes:

_____

_____

_____