5771 South Fort Apache Rd. Ste. 100
Las Vegas, NV 89148
(702) 951-3400

Pediatric Health History

This questionnaire will become a confidential part of your medical record and will help us serve your healthcare needs more effectively. Please fill out this form completely.

Patient's Name:____ DOB: _____________________

Reason for Today's Visit: ____

Allergies To Medication? (circle one) Yes No		
1. _____________________	2.__________________________	3._____________________________

Current Medications (including vitamins & herbs)		
1	2	3

Patient History List any health condition or serious illness that your child has had:	
1	3
2	4
Any Serious Accidents/Broken Bones?	
Was your child ever hospitalized? (circle one) Yes No **Details/Other?:**	

Surgical History (Include Type of surgery and year done)
1
2

Family History (Please list any disease that runs in your child's family & the relationship to child)	

Parents Marital Status: _____________________ Number of Siblings: _______________________
Number of People in Home: ________________ Current Year in School: ____________________

Signature of Parent: _____________________________ Date reviewed by physician with parent: __________