Ringgold Pediatric Clinic

PATIENT HISTORY INFORMATION

Perinatal

Date of birth: _____ Birth Weight: _____

Mother's Name: _____ Age: _____ # of Children ____

Hospital: _____

Breast Fed: Yes No Formula: _____

C-Section: Yes No Group B Strep: Pos Neg

Household Profile

Parents in Household

Biological Mother: Yes No _____

Biological Father: Yes No _____

Divorced: Yes No _____

Smoker: Yes No _____

Cats: Yes No _____

Dogs: Yes No _____

Family/Patient History

	Patient	Other
Allergy/Asthma		
Diabetes		
Heart Disease		
Lung Disease		
Digestive/Ulcer/Liver		
Kidney/Bladder Disease		
Cancer		
Bleeding/Blood Disease		
Birth Defects		
Seizures		
Mental Retardation		
SIDS		
Other		

Hospital/ Surgery/ Truma

Date:	Hospital	Doctor	Diagnosis

Drug Reaction/Allergies

Date:	Medication	Reaction	Allergy?

Date	Problem List	Medication	Doctor/Referral

Name: _____ Date of Birth: _____