Soos Pediatrics, PC
Patient History Form

Childs Name:		DOB:	Today's Date:	
Information regarding the patient:				
Birth Weight:	Type of Birth:	Vaginal	C-section/reason	
Any Complications at birth:		premature (before 38 weeks)	full-term (38+ weeks)	
Pediatrician at Birth if not Dr. Soos		Type of milk:	Breast	Formula:
Hospital at Birth if not Fairview Park Hospital		**MOTHER please indicate:	# of pregnancies	
Mother's Obstetrician			# of live births	

Please answer the following:	Yes	No	List
Any known allergies? (Causing hives, swelling, breathing difficulties)			
Any known sensitivities? (causing nausea/vomiting, diarrhea)			
Any fractures of bones?			
Any Recurrent Illnesses? (ear, sinus, etc.)			
Any Behavior Problems?			
Any concerns regarding growth?			
Any concerns/delay for development?			
speech			
social			
movement (motor)			
Any hospitalizations?			
Any surgeries? (including ear tube/tonsils)			
Take any medications regularly?			
(continue listing routine meds)			
Vitamins/supplements?			
Immunization Record?			Will bring in:

SIBLINGS: Name	Date of Birth
1	
2	
3	
4	
5	

Information regarding the immediate family: (including the child's parent, siblings, grandparents, aunts, uncles)

(Please check any that would apply and list family member)		family member(s)
Any breathing problems (asthma, hay fever)?		
Any heart problems (murmur, heart attack, stroke)?		
Any history of hypertension?		
Any hormone problems (diabetes)?		
Any history of thyroid disease?		
Any skin problems (eczema)?		
Any seizures or convulsion disorders?		
Any history of migraines?		
Any other history of illness/concerns?		

Parents	Married	Divorced	Daycare	Yes	No
Water Type	City	Well	Family Smoking	Yes	No
			Pets in Home	Yes	No

Signature of Parent/Guardian	Date