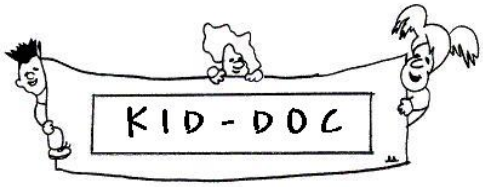


PEDIATRICS

Dr. Shahzad A. Sheikh, MD, FAAP
Pediatric and Adolescent Medicine

Patient Medical History

Name: _____ Male/Female (circle)
DOB: _____

Referred by: _____

Name and Address of Pharmacy: _____
_____

Please complete all questions below and provide details if circled YES

1. Are you allergic to any medication/food(s)? Yes/No (if yes, please list reaction)

_____
_____

2. Are you taking any current medication? Yes/No (if yes, please list name, dose and timing)

_____
_____

_____
_

3. Past Medical History: _____
_____

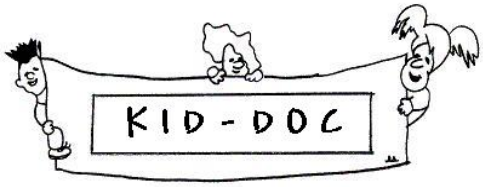
_____
_____

4. Have you had any surgeries? Yes/No (if yes, please list date of surgery and location)

_____
_____

5. Family Medical History (disease and relation to patient): _____
_____

14855 Blanco Rd., #400, San Antonio, TX 78216 ● Office: (210) 492-0900 ● Fax: (210) 492-0977



PEDIATRICS

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_____

_____
_____

6. Smokers in the home? Yes/No Smokers outside the home? Yes/No

7. Patient lives with: Mom Dad Stepparent Sister(s) Brother(s) Grandparents Pet(s)

8. Does the patient have problems in the following areas...
   Behavior/Interaction with peers? Yes/No School performance? Yes/No

Parent's Signature: _____
Date: _____

Rev 3/2020

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