ANGELINA PEDIATRICS, PLLC
MEDICAL INFORMATION

PATIENT'S NAME: ______________________________ TODAY'S DATE : ______________________________

PREGNANCY INFORMATION(THIS CHILD)
AGE OF MOTHER AT TIME OF CHILD'S BIRTH:_______ MOTHER'S BLOOD TYPE: ______________________

TOTAL # OF PREGNANCIES: ______________________ THIS PREGNANCY WAS #: ______________________

OF MISCARRIAGES/STILLBIRTHS/ABORTIONS: _____ # OF LIVING CHILDREN: ______________________

WAS THE PREGNANCY COMPLICATED BY: ANEMIA BLEEDING HIGH BLOOD PRESSURE

INFECTION OTHER: ______________________

BIRTH INFORMATION(THIS CHILD)
CHILD'S PLACE OF BIRTH: ______________________ CITY: ______________________

WHICH MEDICATIONS WERE NEEDED? ______________________

TYPE OF DELIVERY: NORMAL C-SECTION FORCEPS BREECH

BIRTH WEIGHT: ______________ LENGTH: ______________________ BLOOD TYPE: __________

LIST ANY COMPLICATIONS AT BIRTH: ______________________

MEDICAL HISTORY(THIS CHILD)
LIST ANY DRUG ALLERGIES AND REACTIONS: ______________________

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PREVIOUS PHYSICIAN: ______________________ CITY: ______________________

LIST MAJOR ILLNESSES OR DIAGNOSES: ______________________

OF HOSPITALIZATIONS: ________ REASONS: ______________________

OF SURGERIES: ______________ REASONS: ______________________

FAMILY MEDICAL HISTORY
MOTHER'S AGE: ______________ STATE OF HEALTH: ______________________

LIST MAJOR ILLNESSES/MEDICATIONS: ______________________

FATHER'S AGE: ______________ STATE OF HEALTH: ______________________

LIST MAJOR ILLNESSES/MEDICATIONS: ______________________

OTHER SIGNIFICANT MEDICAL PROBLEMS IN RELATIVES: ______________________

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SIBLING INFORMATION
CHILD'S BROTHERS' AND SISTERS' NAMES:

		M	F	STEP SIB.	
______________________	DATE OF BIRTH: ______________	☐	☐	Y	N
______________________	DATE OF BIRTH: ______________	☐	☐	Y	N
______________________	DATE OF BIRTH: ______________	☐	☐	Y	N
______________________	DATE OF BIRTH: ______________	☐	☐	Y	N
______________________	DATE OF BIRTH: ______________	☐	☐	Y	N
______________________	DATE OF BIRTH: ______________	☐	☐	Y	N

EMERGENCY INFORMATION(PERSON TO CONTACT IN CASE OF EMERGENCY OTHER THAN PARENTS)
NAME: ______________________
ADDRESS: ______________________
CITY: ______________________ STATE: ______________ ZIP: ______________
HOME TELEPHONE #: ______________ CELL NUMBER: ______________ WORK NUMBER: ______________
RELATIONSHIP TO PATIENT: ______________________