PEDIATRIC PATIENT INFORMATION

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____

BIRTH DATE: _____/_____/_____ GENDER: MALE_____ FEMALE____

(Month) (Day) (Year)

HOME ADDRESS: _____ZIP:_____

TELEPHONE NUMBERS: Mobile:_____Home:_____

E-Mail: _____

PARENTS/GUARDIANS: _____

Who referred you to our office?_____

Primary Care Physician: _____ Telephone Number: _____

Do you want us to notify your physician of this visit? Yes ____ No _____

In case of emergency, whom should we contact? _____Telephone:_____

Where was your child born?_____

How long have they been living in South Florida? _____

Have they traveled overseas before? Yes ___ No ___

Departure Date_____

Itinerary- Please indicate where your child is travelling and the length of stay in each area:

1-_____

2-_____

3-_____

4-_____

5-_____

6-_____

PERSONAL HISTORY

When did the pediatrician last see your child? _____

Does your child have any medical problems? Yes ___ No ___
Explain: _____

Does your child have a medical condition that is stable now but may recur while traveling? Yes ___ No ___
Explain: _____

Does your child have any other immune disorder, leukemia, or cancer? Yes ___ No ___
Explain: _____

Has your child ever been hospitalized for any illness? Yes ___ No ___
Explain:_____

Has your child had any transfusions of blood or blood products? Yes ___ No ___
Explain: _____

Has your child had any operations? Yes ___ No ___
Explain: _____

Does your child have any allergies? Yes ___ No ___
Explain:_____

Does your child take any medications? Yes__ No___
Name of medications:_____

Has your child had all the necessary immunizations? Yes ___ No ___

Date of last menstrual period (if applicable) _____

Please list any other comments or concerns:
_____
_____
_____
_____
_____
_____
_____

Current Weight:_____

Parent/Guardian Signature:_____