

TODAY'S DATE: _____

Framingham Pediatrics

Demographics Form

Your Pediatrician: (please circle)

Your Pediatrician (please circle): Dr. Baumel, Crawford, Garber, Hicks, Rosselot, Whitman

(please use back of page if you need more space)

DEMOGRAPHICS

Child's Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:	City:	ZIP:
Home Phone:	Cell Phone:	Social Security #:
Home Email:		
Mother/guardian #1:	DOB:	Social Security # :
Employer:	Work Phone:	
<input type="checkbox"/> information is the same as above		
Address:		Email:
Home phone:	Cell Phone:	
Father/guardian #2:	DOB:	Social Security #:
Employer:	Work Phone:	
<input type="checkbox"/> information is the same as above		
Address:		Email:
Home Phone:	Cell Phone:	
Insurance Company:	Under <input type="checkbox"/> Mother <input type="checkbox"/> Father	
Emergency Contact:	Relationship:	
Home Phone:	Cell Phone:	
Preferred Pharmacy:		

Patient Name: _____

Today's Date: _____ / _____ / _____

Medical History Review

Your Pediatrician (please circle): *Dr. Baumel, Crawford, Garber, Hicks, Rosselot, Whitman*
(please use back of page if you need more space)

PATIENT'S PAST MEDICAL HISTORY (check all that apply, fill in any others)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Birth: Full term/Premature (wks) _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Other: _____ |

PATIENT'S MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other:
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other:

PATIENT'S CURRENT MEDICATIONS (liquid/chewable/pill, dosage and frequency)

1.	3.
2.	4.

PATIENT'S SURGERIES/HOSPITALIZATIONS

PROBLEM	HOSPITAL	DATE

FAMILY HISTORY (check all that apply, list family member and age of onset)

(please address any questions to your pediatrician)

Mother's health history:

Father's health history:

Sibling (name/age), major medical problems:

- | | |
|----|----|
| 1) | 3) |
| 2) | 4) |

Have any of the patient's parents or grandparents had a heart attack, stroke or high cholesterol before age 60? Y / N (If yes, please explain)

Is there any family history of sudden or unexplained death? Y / N (If yes, please explain)

Has anybody in the family ever had chest pain or heart symptoms related to exercise or exertion? Y / N (If yes, please explain)

Is there any family history of obesity or weight problems? Y / N (If yes, please explain)