PEDIATRIC GYNECOLOGY
Associates, P.C.

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth:_____

Why is your child being seen today? _____

_____

Has your child had any test performed recently?_____

_____

Is your child on any medication? Please list and include any regular medications your child takes daily and dosage: _____

_____

Is your child generally medically well? ___ yes ___ no

If you answered no, please explain and list any chronic medical conditions (example: spina bifida, Down's Syndrome, bleeding disorder, etc):

_____

_____

Does your child have allergies: ___ yes _____ no
If yes, please list: _____

Type of allergic reaction (please describe symptoms example: hives, trouble breathing, etc):_____

List any surgeries your child has had and when the surgery was done:
Date (month/year) Type of Surgery:

_____

_____

List any hospitalizations (overnight stay in the hospital)
Date (month/year) Reason for hospitalization:

_____

_____