UT★Physicians
A Part of UTHealth

PEDIATRIC PATIENT INFORMATION

Patient Name_____ DOB _____ AGE _____

Name Child Likes to be Called _____

Mother

Name _____

Home Address _____

_____

Home Phone_____

Work Address _____

_____

Work Phone_____

Cell Phone _____

Email _____

Father

Name _____

Home Address _____

_____

Home Phone_____

Work Address _____

_____

Work Phone_____

Cell Phone _____

Email _____

Referring Physician

Name_____

Address_____

City _____State_____

Zip_____

Phone_____

Fax _____

Pharmacy Name &

Pharmacy Phone _____

_____

Pediatrician/Family Doctor

Name_____

Address_____

City_____ State _____

Zip _____

Phone_____

Fax _____

Reason for you visit today _____

_____

(CONTINUE....)

Has your child ever had or does he/she now have.....?

	Yes	No	Date
Prematurity			
Heart Problems			
Lung Problems			
Kidney Problems			
Liver Problems			
Rheumatic Fever			
Hepatitis (Yellow Jaundice) (Type _____)			
Venereal Disease (Syphilis, Gonorrhea, Chlamydia)			
Herpes			
High Blood Pressure			
Tuberculosis			
Asthma			
Hay Fever			
Eczema			
Diabetes (Type_____)			
Thyroid Disease (Type_____)			
Sensitivity to Sunlight			
Lupus Erythematosus			
Seizures or Epilepsy			
Cancer of any type (Type_____)			
Skin Cancer			
Anemia or Blood Problems			
Nervous or Mental Problems			
Recent Weight Loss/Gain			
Artificial Heart Valves or Prosthesis			
Do you require antibiotics before Procedures?			

Does anyone in your family have a history of....?

	Yes	No	Date
Melanoma			
Basal Cell Carcinoma			
Squamous Cell Carcinoma			
Unknown type of skin cancer			
other			

Other Medical History_____

_____

Current Medication_____

_____

Childs Allergies _____

Name_____ **DOB** _____