

PATIENT INFORMATION SHEET

DATE _____

CHILD'S NAME: _____

Preferred name/pronoun: _____

DOES YOUR CHILD TAKE MEDICATIONS ROUTINELY FOR ANY MEDICAL PROBLEM? PLEASE INCLUDE OVER-THE-COUNTER AND TOPICAL (CREAMS OR OINTMENTS) MEDICINES.

ANY HISTORY OF CHRONIC MEDICAL PROBLEMS (ASTHMA, ALLERGY, ETC.)?

IS YOUR CHILD ALLERGIC TO ANY MEDICINES? IF SO, WHAT MEDICATIONS?

ANY ADVERSE REACTIONS TO VACCINES IN THE PAST?

YES _____ NO _____

HAS YOUR CHILD EVER BEEN ADMITTED TO THE HOSPITAL (OTHER THAN EMERGENCY ROOM VISITS)?

HAS YOUR CHILD EVER HAD SURGERY? WHAT? WHEN?
