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?

_____

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