Patient Profile Update:

Patient name: _____ Date of birth: _____ Today's date: _____

Age of patient: _____ Patient's address: (if no change since last visit, leave blank)

_____

_____

Since this patient's last visit to Pediatrics Plus, have there been any changes in his/her insurance carrier, or custody? If yes, list change(s) here. (if no changes, leave blank) _____

_____

_____

_____

Patient's Medical History: Since patient's last visit to Pediatrics Plus, have there been any changes in your answers to the questions below? If yes, check yes and list.

	Yes	No	If yes, list below
Is patient under a physician's care now for any medical condition?	___	___	_____
Has patient been hospitalized or had a major operation?	___	___	_____
Has patient had a major head or neck injury?	___	___	_____
Has patient had any significant illnesses or injuries?	___	___	_____
Is patient presently taking any medications?	___	___	_____
Is patient presently on a special diet?	___	___	_____
Does patient have any new allergies?	___	___	_____

Has patient been diagnosed with any new significant medical conditions since last visit? If yes, list: _____

_____

Family History:

Since the last visit to Pediatrics Plus, has any family member been diagnosed with any disease that may be hereditary or place this patient at risk? ___ Yes ___ No If yes, give here: _____

If no changes in the information below since last visit, simply write same after father's and mother's name.

Father's name: _____

Address: Street: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Father's phone #: (H) _____ (C) _____ (W) _____

Does father use tobacco? ___ Yes ___ No Is father in overall good health? ___ Yes ___ No

Is father deceased? ___ Yes ___ No If yes, cause of death: _____

Mother's name: _____

Address: Street: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Mother's phone #: (H) _____ (C) _____ (W) _____

Does mother use tobacco? ___ Yes ___ No Is mother in overall good health? ___ Yes No ___

Is mother deceased? ___ Yes ___ No If yes, cause of death: _____

Has any family member (parent, grandparent, biological sibling, aunt or uncle) been diagnosed with any new medical condition since your last visit here? ___ Yes ___ No.

If yes, list here: _____

Social History: Below, list only changes since last visit.

Grade in school: _____ School attending: _____

Is patient exposed to tobacco smoke or excess alcohol consumption in the home? ___ Yes ___ No

Patient lives with: ___ mother ___ father ___ both ___ Other: _____

	Yes	No	
Does patient use tobacco, alcohol or controlled substances?	___	___	If yes, what? _____
Is patient sexually active?	___	___	
Is patient on oral contraceptives?	___	___	
Has patient ever been pregnant?	___	___	
Do you have concerns that this patient may be abusing drugs?	___	___	
Is patient employed?	___	___	If yes, where? _____

My signature below attests to the fact that I, the parent or legal guardian of this patient, have completed this form to the best of my ability and that my answers to the questions are complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

This form was reviewed on _____ by _____