

Dr. Ruth Bernardez-Tan

MEDICAL HISTORY

Patient's Name:			Birth Length:		
	Pregnancy Complications:				
	Delivery: Vaginal	C-Section		Complications	
Devel	opmental History: Normal Delayed				
Previo	ous Hospitalizations:				
	ous Surgeries:				
	gies:				
Curre	ent Medications:				
Famil	y History:				
Does y	your child have, or has he/she had, an	y of the following?			
Yes	No		Yes	No	
	Anemia			Hemophilia	
	ADD/ADHD Asthma		-	Hepatitis A, B, C High blood pressure	
	Asuma Blood disorder/Leukemia			Kidney problems	
	Chest pains			Kidney problems Liver problems	
	Convulsions/seizures			Livel problems Lung disease	
	Diabetes			Psychiatric problems	
	Diabetes Drug addictions			Tsychiatric problems Weight loss	
	Excessive bleeding			Scarlet fever	
	Excessive thirst			Sickle Cell trait/disease	
	Fainting spells/dizziness			Stomach/intestinal problems	
	Frequent/chronic cough			Thyroid disease	
	Frequent headaches			Tunors or growths	
	Heart murmur			Ulcers	
	Heart murmur Heart problems			Venereal disease	
	iteart problems			Other problems not mentioned	
To th	ne best of my knowledge, the questi	ons on this form h	ave bee	en accurately answered. I understand that	
provi	ding incorrect information can be	dangerous to my	child's ł	health. It is also my responsibility to inform the	
_	of any changes in my child's med				
Signature of Parent/Guardian			_	Date	