EMMANUEL PROJECT

MEDICAL HISTORY FORM

PATIENT FIRST NAME:	PATIENT LAST NAME;	PATIENT DATE OF BIRTH:
BIRTH HOSPITAL:	BIRTH WEIGHT:	BIRTH HOSPITAL:
_____ VAGINAL _____ C-SECTION	WEEKS GESTATION: _____	IS THE PATIENT A MULTIPLE (TWIN, TRIPLET ETC.) _____ YES _____ NO
IF C-SECTION, WHY?	DID THE PATIENT REQUIRE INTENSIVE CARE / NICU? _____ YES _____ NO	MOTHER'S OBSTETRICIAN NAME:

LIST ANY BIRTH COMPLICATIONS, DEFECTS OR ABNORMALITIES:

DID YOUR CHILD HAVE ANY OF THE FOLLOWING AT BIRTH:

JAUNDICE REQUIRING PHOTOTHERAPY
RESPIRATORY DISTRESS REQUIRING OXYGEN/MECHANICAL VENTILATION
FAILED NEWBORN HEARING SCREENING
HEART MURMUR REQUIRING EVALUATION
ABNORMAL ULTRASOUND
FEVER/INFECTION

LIST ANY KNOWN ALLERGIES AND TYPE OF REACTION

LIST ALL CURRENT MEDICATIONS:

LIST ALL PREVIOUS / DISCONTINUED MEDICATIONS:

PLEASE LIST ANY HOSPIITALIZATIONS / SURGERIES

DATE	HOSPITAL NAME/LOCATION	REASON
DATE	HOSPITAL NAME/LOCATION	REASON
DATE	HOSPITAL NAME/LOCATION	REASON

WERE THERE ANY NEGATIVE REACTIONS TO ANESTHESIA? _____ YES _____ NO

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MEDICAL HISTORY, cont.

LIST ANY OTHER PROVIDERS WHO SEE YOUR CHILD:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? (check all that apply)

ADHD
ASTHMA
BLOOD DISORDER
DIABETES
HEART MURMUR
KIDNEY DISEASE
RECURRENT EAR INFECTIONS
RECURRENT INFECTION
RECURRENT U.T.I
SEIZURES
SICKLE CELL ANEMIA
TRAUMA/ACCIDENT

PLEASE EXPLAIN ANY ITEM CHECKED ABOVE OR OTHER HISTORY OUR PROVIDER'S SHOULD BE AWARE OF:

CHECK ANY THAT APPLY TO YOUR CHILD:

*BOTTLE FED until what age?*_____

BREASTFED until what age? _____

PACIFIER USE until what age? _____

DOES YOUR CHILD ATTEND DAYCAR? _____ *YES* _____ *NO*

PLEASE LIST WHO LIVES IN THE HOUSEHOLD:

DOES ANY HOUSEHOLD MEMBER OR CARETAKER SMOKE? _____ YES _____ NO

HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH THE FOLLOWING? (Circle and indicate relationship)

ASTHMA
ALLERGIC RHINITIS
CANCER
DEPRESSION
DIABETES
GALLSTONES
HEART DISEASE
HEPATITIS
HIGH CHOLESTEROL
HIGH BLOOD PRESSURE
INFLAMMATORY BOWEL DISEASE
KIDNEY DISEASE
KIDNEY STONES
MENTAL ILLNESS
MIGRAINE HEADACHES
SICKLE CELL ANEMIA
OTHER ANEMIA
STROKE
THYROID DISEASE
ULCERS

EMMANUEL PROJECT

TODAY'S DATE:
FECHA:

PRIMARY LANGUAGE SPOKEN:
IDIOMA PRINCIPAL :

DO YOU NEED A TRANSLATOR YES ☐
NECESITA UN TRADUCTOR?: NO ☐

SSN:

CHILDS LEGAL FULL NAME
NOMBRE COMPLETO DEL NINO

DATE OF BIRTH
FECHA DE NACIMIENTO

☐ MALE / MASCULINO ☐ FEMALE / FEMENINO

SSN:

CHILDS LEGAL FULL NAME
NOMBRE COMPLETO DEL NINO

DATE OF BIRTH
FECHA DE NACIMIENTO

☐ MALE / MASCULINO ☐ FEMALE / FEMENINO

SSN:

CHILDS LEGAL FULL NAME
NOMBRE COMPLETO DEL NINO

DATE OF BIRTH
FECHA DE NACIMIENTO

☐ MALE / MASCULINO ☐ FEMALE / FEMENINO

HOME ADDRESS :
DIRECCION:

CITY:
CIUDAD:

STATE :
CIUDAD:

ZIP CODE:
APARTADO POSTAL:

PRIMARY PHONE NUMBER:

EMAIL:

PREFERRED METHOD OF CONTACT:

EMAIL ☐ TEXT ☐ PHONE ☐

PREFERRED PHARMACY:

PHARMACY INTERSECTION

MOTHERS FULL NAME:
NOMBRE COMPLETO DE LA MADRE:

SSN:

DOB:

CELL PHONE NUMBER:
NUMERO CELULAR :

WORK NUMBER:
NUMERO TRABAJO:

FATHERS FULL NAME:
NOMBRE COMPLETO DE LA PADRE:

SSN:

DOB:

CELL PHONE NUMBER :
NUMERO CELULAR:

WORK NUMBER:
NUMERO TRABAJO:

MARRIED / CASADO ☐ SINGLE / SOLTERO ☐ WIDOWED/VIUDO ☐ DIVORCED/DIVORCIADO ☐

RACE: RELIGION: ETHNICITY: