VALLEY PEDIATRIC ASSOCIATES, L.L.C.

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PATIENT NAME: _____ DOB: ___/___/_____

Person Filling out Form: _____ Today's Date: ___/___/_____

PAST MEDICAL HISTORY	DATE STARTED	DATED ENDED (IF APPROPRIATE)
Nasal allergies or other allergies		
Asthma / lung disease		
Heart disease or heart condition		
High blood pressure		
High cholesterol		
Thyroid Disease		
Diabetes or other endocrine problem		
Cancer		
Anemia		
Bleeding disorder		
Epilepsy or convulsions		
Mental retardation or developmental disorders		
Migraines		
Neurologic disorder		
Learning problems or ADD		
Inflammatory Bowel Disease / Crohn's / Colitis		
Liver Disease		
Other GI disease / disorder		
Kidney Disease		
Bedwetting after 10 years old		
Hearing impairment		
Vision impairment or eye disorder		
Immune problems, recurrent infections, HIV / AIDS		
Alcohol Abuse		
Drug Abuse		
Mental Illness		
Tuberculosis		
Any other medical problems not mentioned above		