VALLEY PEDIATRIC ASSOCIATES, LLC

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PATIENT NAME: _____ DOB: _____/_____/_____

PERSON FILLING OUT FORM: _____ TODAYS DATE: _____/_____/_____

PAST MEDICAL HISTORY	NO	YES	DATE STARTED	DATED ENDED
Complications in pregnancy, delivery, or post-partum; NICU stay				
Hospitalizations (not including birth)				
Surgery				
Sees Specialists				
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				
Neurologlc disorder				
Learning problems or ADD				
Inflammatory Bowel Disease/ Crohn's / Colitis				
liver Disease				
0ther 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				