Orchard Pediatrics, PC
West Bloomfield, MI 48322

Newborn through Adolescent Care

.

PATIENT AND FAMILY HISTORY

Child's name_____DOB_____

PLEASE GIVE DETAILS ABOUT YOUR CHILD'S HISTORY OF:

Serious illnesses or medical conditions_____

Serious injury or accident (Year/Details)_____

Surgeries (Year/Reason)_____

Hospitalizations (Year/Reason)_____

Behavioral or mental health issues/diagnosis_____

Receiving ongoing medical care from a specialist_Y/N___Type of Specialist _____

Reason_____

Recurring medical problems_____

Significant family medical problems (Who/Problem)_____

Name of Parent #1_____preferred title (Mr/Mrs/Ms/Dr/other)_____

Occupation_____genetic parent of child Y/N_____

Name of Parent #2_____preferred title (Mr/Mrs/Ms/Dr/other)_____

Occupation_____genetic parent of child Y/N_____

Other co-parent or guardian name_____relationship to child_____

Which parents/siblings live with child?_____

Who has LEGAL authority to consent to vaccines or treatment?_____

SIGNATURE AND RELATIONSHIP TO CHILD **DATE** **DR INITIALS** **NURSE INITIALS**