

# PATIENT FRONT SHEET

TODAY'S DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ SEX: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

\*\*HOME PHONE: \_\_\_\_\_ \*\*CELL PHONE: \_\_\_\_\_

***CIRCLE PREFERRED NUMBER TO CALL***

BUSINESS NAME: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

FATHER'S/PARTNER'S NAME: \_\_\_\_\_ SSN#: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

\*\*HOME PHONE: \_\_\_\_\_ \*\*CELL PHONE: \_\_\_\_\_

***CIRCLE PREFERRED NUMBER TO CALL***

BUSINESS NAME: \_\_\_\_\_ BUSINESS NUMBER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Name and date of birth of all other dependent children: \_\_\_\_\_

\_\_\_\_\_

Parent's Marital Status: \_\_\_\_\_

In case of emergency, notify (other than parent, name and phone number)

\_\_\_\_\_

Person responsible for payment: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

**PLEASE SEE REVERSE SIDE**

Alan C. Johnson, M.D.  
Margaret M. Miller, M.D.

Katherine Crosby, M.D.  
Michelle Pepitone, M.D.

Susan B. Dab, M.D.  
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## PEDIATRIC PATIENT HISTORY

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Informant (Relationship to patient): \_\_\_\_\_

Previous Pediatrician: \_\_\_\_\_ Location: \_\_\_\_\_

**MOTHER'S HISTORY: (circle the appropriate response)**

**PREGNANCY:**

- |                    |    |     |
|--------------------|----|-----|
| 1. Illnesses       | NO | YES |
| 2. Drugs           | NO | YES |
| 3. Prematurity     | NO | YES |
| 4. Hospitalization | NO | YES |
| 5. Bleeding        | NO | YES |
| 6. Smoking         | NO | YES |
| 7. Drinking        | NO | YES |

**LABOR AND DELIVERY:**

- |                     |    |     |
|---------------------|----|-----|
| 9. Cesarean Section | NO | YES |
| 10. Prolonged Labor | NO | YES |
| 11. Complications   | NO | YES |

**NEWBORN STAY:**

- |                   |    |     |
|-------------------|----|-----|
| 1. Prolonged Stay | NO | YES |
| 2. Jaundice       | NO | YES |
| 3. Other: _____   |    |     |

Comments on **YES** responses: \_\_\_\_\_

**PATIENT'S HISTORY**

- |                        |    |     |                                         |    |     |
|------------------------|----|-----|-----------------------------------------|----|-----|
| 1. Allergic to _____   |    |     | 3. Hospitalizations                     | NO | YES |
| a. medication          | NO | YES | 4. Surgeries                            | NO | YES |
| b. other               | NO | YES | 5. Dental Problems                      | NO | YES |
| 2. Childhood Illnesses |    |     | 6. Injuries, Poisonings                 | NO | YES |
| b. Ear infections      | NO | YES | 8. Vaccine reactions                    | NO | YES |
| c. Asthma              | NO | YES | 9. Current medications                  | NO | YES |
| d. Frequent colds      | NO | YES | 10. Vision or hearing problems          | NO | YES |
| e. Stomach problems    | NO | YES | 11. Daycare/Preschool                   | NO | YES |
| f. Other _____         |    |     | 12. Learning or developmental problems? | NO | YES |

Comments on **YES** responses: \_\_\_\_\_

**FAMILY MEDICAL HISTORY: (includes mom, dad, aunts, uncles, and grandparents)**

Are there any immediate family members who have a special medical problem or who are on special medications? **NO** **YES** \_\_\_\_\_

Are there any immediate family members who have died of medical causes? **NO** **YES** \_\_\_\_\_

**IF SO, WHO? \_\_\_\_\_ CAUSE? \_\_\_\_\_**

Are there any immediate family members who have these conditions? If yes, which members?

- |                                                                              |    |     |
|------------------------------------------------------------------------------|----|-----|
| Allergies, asthma, eczema                                                    | NO | YES |
| High cholesterol or triglycerides                                            | NO | YES |
| Heart Disease                                                                | NO | YES |
| High Blood Pressure                                                          | NO | YES |
| Endocrine Disorders (Diabetes, thyroid disorder)                             | NO | YES |
| Anemia, blood disorder, bleeding problems                                    | NO | YES |
| Autoimmune Disease (Lupus, Rheumatoid Arthritis)                             | NO | YES |
| Tuberculosis, positive skin test                                             | NO | YES |
| Cancer                                                                       | NO | YES |
| Seizure or convulsion disorder                                               | NO | YES |
| Vision, hearing or speech problems                                           | NO | YES |
| Learning disabilities or developmental delay                                 | NO | YES |
| Birth Defects                                                                | NO | YES |
| Domestic Violence                                                            | NO | YES |
| Cigarette Use                                                                | NO | YES |
| Any psychological or mood disorders,<br>(Depression, anxiety, schizophrenia) | NO | YES |