PEDIATRIC SURGERY, P.A.
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Today's Date: _____ Child's Name: _____

Child's Race: _____ Child's Ethnicity: _____

Language: _____ Date of Birth: _____

Person Completing this Form: _____

Your Relationship to the Child: _____

1. Please list the problem(s) your child is here for today: _____

_____

_____

2. Has your child been seen by our doctors before? (Please list when, where & why.) _____

_____

_____

3. Have any other members of your family been treated by our doctors? (Please list who, when & why.)

_____

_____

4. Please list other medical problems your child has. (Please include all previous surgeries and/or hospital stays.) _____

_____

_____

5. Please list any allergies or unusual drug reactions your child has had: _____

_____

_____

6. Please list any/all medications your child is currently taking: _____

_____

_____