

All Better Pediatrics, PC

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PATIENT HISTORY FORM

Person completing form: _____

Date: _____

Child's Name: _____

DOB: _____

Child's History:

Birth Weight: _____ Complications at Birth: _____

Hospitalizations & Surgery(s): _____

Chronic Illnesses: _____

Significant Injuries: _____

Chicken Pox: Yes/No Date: _____ Are Immunizations Current: Yes/No

Educational and Academic History: _____ Current Grade: _____

Other physicians/specialists involved in your child's care: _____

Review of Systems

Please check if your child has any problems in the following body systems.

Problems	No Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional (unexplained fevers, weight gain or loss, cancer leukemia, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat (Chronic Ear or Sinus Infections)
<input type="checkbox"/>	<input type="checkbox"/>	Heart or Blood Vessels (Murmur, High Blood Pressure, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease)
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Tract (Diarrhea, Constipation, GERD, Liver, Jaundice)
<input type="checkbox"/>	<input type="checkbox"/>	Joints, Muscles, Extremities (Arthritis, Scoliosis)
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Neurological System (ADHD, LD, CP, Seizures, Mental Retardation)
<input type="checkbox"/>	<input type="checkbox"/>	Psychological or Mental Health (Depression or Anxiety)
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (Glandular Problems, Diabetes, Thyroid Disease)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease (Sickle Cell Disease, SC Trait, Hemophilia, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Immunology (Chronic Allergies, Immune Deficient)
<input type="checkbox"/>	<input type="checkbox"/>	Bladder and Kidney (Chronic UTI's, Kidney Problems)

Family History:

Siblings: Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____