



3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

### New pediatric patient information and history form

Name	DOB	Occupation	Please list any chronic health problems	Living in the home?
Mother's name:				
Father's name:				
Other adult(s) in home:				
Guardian's name:				

Other children in home	DOB	Sex	Relationship to patient

Related children not in home	DOB	Sex	Relationship to patient

Please check if any family member has any of the following from the patient's point of view:

	Alcohol Abuse	Allergies (Seasonal)	Asthma	Birth Defect	Developmental Delay	Diabetes	Drug Abuse	Early Heart Attack-under 50	Early Stroke under 50	Hearing Loss	Hepatitis	High Blood Pressure	High Cholesterol	Hip Dislocation at Birth	Learning Problems/ADHD	Mental Health/Depression	Obesity	Sudden Death	Tuberculosis	
Mother																				
Father																				
Sister																				
Brother																				
Aunt (M)																				
Uncle (M)																				
Aunt (F)																				
Uncle (F)																				
Gma (M)																				
Gpa (M)																				
Gma (F)																				
Gpa (F)																				

\*Mother's side (M) Father's side (F) Grandmother (Gma) Grandfather (Gpa)

Does your child have any medical problems?

Has your child had any surgeries? If yes, please describe.