Raleigh Pediatric Associates
Patient Information and Medical History

Date: _____

Chart #: _____

Patient's Legal Name: _____ _____ _____
(First Name) (MI) (Last Name)

Patient's Preferred Name: _____ **Date of Birth:** _____

Patient History:

Recurrent Illness: _____

Allergies: _____

Previous Hospitalizations: _____

Previous Surgeries: _____

Behavior Problems: _____

Current Medications: _____

Other: _____

Mother / Legal Guardian

Name: _____ ____ _____
(First) (MI) (Last)

DOB: _____

Occupation: _____

Health Problems:

_____

_____

_____

Father / Legal Guardian

Name: _____ ____ _____
(First) (MI) (Last)

DOB: _____

Occupation: _____

Health Problems:

_____

_____

_____

Please list all siblings:

NAME	GENDER	DATE OF BIRTH	HEALTH PROBLEMS

Any significant history of disease or medical problem in a close *biological* relative? ____ No ____ Yes

If Yes, please specify _____

Any relatives with sudden death prior to age 50? ____ No ____ Yes

If Yes, please specify _____

Office Use Only --- EHR Entry Completed Nurse Initials: _____ hw/mn 7/2018