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## PATIENT HISTORY FORM

Be sure to download and save this document to your computer. This form can be filled out on your computer and emailed to alphaped101@gmail.com or print the form out and bring it to the office filled out. Thank You!

### PATIENT HISTORY FORM:

Please fill out as much information as you can *(if you have any questions please ask the nurse)*

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Grade In School: \_\_\_\_\_

Please List Any Diseases From Which Your Child Suffers *(Specify When Diagnosed)*: \_\_\_\_\_

Please List Any Surgeries *(Operations)*, Reason For The Surgery, And Date Of Surgery: \_\_\_\_\_

Family History *(Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives)*:

If history is unknown please place an "X" here: \_\_\_\_\_

	Father	Mother	Maternal Grandpa	Maternal Grandma	Paternal Grandpa	Paternal Grandma	Brother	Sister
Cancer (specify)								
Heart Disease								
Diabetes								
High Blood Pressure								
High Cholesterol								
Alcohol/Drug Abuse								
Depression/ Psychiatric Illness								
Genetic Disorder (specify)								
Other (specify)								

IF ANY OTHER BLOOD RELATIVES HAVE ANY OF THE ABOVE DISEASES PLEASE LIST THEM HERE: \_\_\_\_\_

Please list any allergies or adverse drug reactions *(drug and type of reaction)*: \_\_\_\_\_

### CURRENT MEDICATIONS:

Name of Medication	Start Date	Dose	How often taken

Sign: \_\_\_\_\_ Date: \_\_\_\_\_