

Dr. Ruth Bernardez-Tan

MEDICAL HISTORY

Patient's Name:	D.O.B:	
Birth History: Birth Weight:	Birth Length:	
Gestational Age:	Birth Place:	
Pregnancy Complications:		
	C-Section Complications	
Developmental History: Norma Delaye	al	
Current Medications:		
PHARMACY INFORMATION:		
Pharmacy name:		
Pharmacy Phone number:		
Address or Cross Streets:		
Does your child have, or has he/she had a	any of the following?	
Yes No Anemia ADD/ADHD Asthma Blood disorder/Leukemia Chest pains Convulsions/seizures Diabetes Excessive bleeding Fainting spells/dizziness	Yes No	problems s ed Infections
To the best of my knowledge, the questio information can be dangerous to my child medical status.	ns on this form have been accurately answered. I understand that pr d's health. It is also my responsibility to inform the clinic of any char	roviding incorrect nges in my child's

Date

Signature of Parent/Guardian