

**Avon Pediatrics Kerry Hensley, M.D. Erik Cox, M.D. (317) 272-7887**  
**Patient Information and Medical History**

Demographics	
Name: _____	Gender: _____
Birthdate: _____	Soc. Sec #: _____
Who does this child live with: _____	

Relationship	DOB	General Health
Father		
Mother		
Sibling		
Sibling		
Sibling		

Please answer with a check mark if any of the following conditions apply to *any member of your family* including grandparents, aunts and uncles.

Allergy	Alcohol	Arthritis
Asthma	Tobacco	Heart Attack <50 years old
Cancer	Thyroid	Tuberculosis
Diabetes	Developmental Delay	Cystic Fibrosis
Heart Disease	Vision	Epilepsy
Psych	Hypertension	Frequent Infections

Birth History	
Delivery Hospital: _____	OB: _____
Number of Pregnancies: _____	Full term?: _____
Delivery: Vaginal/C-section	
Birth Weight: _____	Length: _____
Head Circumference: _____	
Mothers Bld Type: _____	Infants Bld Type: _____
Feeding: _____	
Condition at Birth: _____	Hearing Screen: Passed/Failed
Problems at Birth: _____	
After birth did your baby have: Jaundice(yellow)? _____	
Require Oxygen? _____	How Long? _____
Discharge Date: _____	Discharge Wt.: _____

Past Medical History	
General Health: _____	
Ongoing Medical Problems: _____	
Hospitalizations/Surgery(when and what for): _____	
Chicken Pox: _____	
Smoke Exposure: _____	
Alcohol: _____	
Injuries: _____	
Seizures: _____	
Loss of Consciousness _____	

Is the patient allergic to any medications? If so, please list the medication and what kind of reaction: \_\_\_\_\_

Is the patient on any medication? If so, what kind, how much and how often? \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Updated: \_\_\_\_\_ Initials: \_\_\_\_\_

Updated: \_\_\_\_\_ Initials: \_\_\_\_\_