

CONFIDENTIAL

RICHARD A. HARDOIN, M.D.
GERALD BOTTENFIELD, M.D.
54 Flag Lake Plaza, Lake Jackson, Texas 77566

DATE _____

PATIENT INFORMATION SHEET

PATIENT _____ BIRTHDATE _____ AGE _____
FATHER'S NAME _____ MOTHER'S NAME _____

CONSENT FOR TREATMENT: Authorization of treatment for my child. Emergency treatment in the event my child is brought in by any person other than myself.

Signature of parent or guardian: _____

BIRTH AND DEVELOPMENT

BIRTHPLACE _____ HOSPITAL _____

PREGNANCY: # OF MONTHS _____ VAGINAL _____ C-SECTION _____

DURATION OF LABOR _____ TYPE OF ANESTHETIC _____ COMPLICATIONS _____

BIRTH WEIGHT _____ BIRTH LENGTH _____ CONDITION AT BIRTH _____ JAUNDICE _____

BREAST FED? _____ DURATION _____ FORMULA TYPE _____ AMOUNT/DAY _____

WHOLE MILK _____ LOFAT _____ SKIM _____ AMOUNT/DAY _____

APPETITE(good, fair, poor) _____ MEALS/DAY _____ FEEDING PROBLEMS _____ COLIC _____

WAS YOUR CHILD EVER HOSPITALIZED? _____ WHEN/WHY _____

AT WHAT AGE DID YOUR CHILD DO THE FOLLOWING:

SMILE _____ ROLLOVER _____ SIT UP _____ CRAWL _____ FIRST WORDS _____

FIRST TOOTH _____ SHORT SENTENCES _____ WALKED _____

TOILET TRAINED: STOOL _____ BLADDER _____

DOES YOUR CHILD STOOL DAILY? _____ IF NO, HOW OFTEN? _____ WET THE BED? _____

BITE HIS/HER NAILS? _____ SUCK HIS/HER THUMB? _____ EVER HAD HIVES? _____ ALLERGIC TO MEDICATION? _____

DRUG NAMES _____

HAS YOUR CHILD EVER HAD THE FOLLOWING DISEASES?

Name	No	Yes	Date	Name	No	Yes	Date	Name	No	Yes	Date
Roseola				Scarlet Fever				Tonsillitis			
Whooping Cough				Diphtheria				Convulsions			
Measles				Hay Fever				Severe Constipation			
German Measles				Rheumatic Fever				Severe Diarrhea			
Mumps				Ear Infections				Pneumonia			
Chicken Pox				Urine Infections				Bronchitis			
Strep Throat				Rupture Ear Drum				Frequent Stomach Aches			
Hearing Loss				Speech Defect				Fractured Skull			
Broken Bone				Operations							

FAMILY HISTORY: IS THERE A FAMILY HISTORY OF THE FOLLOWING DISEASE?

DIABETES _____ WHO _____ HAY FEVER _____ WHO _____

TUBERCULOSIS _____ WHO _____ BLEEDING TENDENCIES _____ WHO _____

ASTHMA _____ WHO _____ CONVULSIVE DISEASE _____ WHO _____

EARLY ATHEROSCLEROSIS (heart attack at age less than 40) _____ WHO _____

OTHER DISEASES(birth defects, Cystic Fibrosis, etc.) _____ WHO _____

IS THERE ANYTHING INTERESTING OR SPECIAL THAT I SHOULD KNOW ABOUT YOUR CHILD?