Patient Name_____ Acct.. # _____ DOB_____

**Hospitalizations** _____

**Social and Environmental History** _____

Type of Heat _____ Water Source _____ Sewage Disposal _____

Smokers in Home _____ Pets _____

Performance in School _____

**ALLERGIES *** ALLERGIES *** ALLERGIES *** ALLERGIES *** ALLERGIES *** ALLERGIES**

To Medications: _____

To Other Substances: _____

**IMMUNIZATIONS**

| DTaP/DT | HIB | Polio | Hep B | Prevnar | MMR | Td |
|---|---|---|---|---|---|---|
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| | | | | | | |
| | | | | | Varicella | |
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**Problem List**

| Date | Diagnosis, Condition or Symptom | Treating Physician | Date Resolved |
|---|---|---|---|
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