Chester County Pediatrics
1244 Cornerstone Blvd
Downingtown, PA 19335
610-873-5437

Date: _____

Patient Information Sheet

Name: _____ **DOB:** _____

Address: _____

Allergies: _____

List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken.

Medications	**OTC and Vitamins**
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History:

_____

_____

_____

Surgical History: **PLEASE list ALL prior surgeries and approximate dates performed**

_____

_____

_____

Hospitalizations: _____

_____

_____

Birth History: Vaginal C-Section

Complications: _____

Breast Feed: YES NO

Formula (Brand and Type) _____

Weight: _____ **Height:** _____ **Head Circumference:** _____

Does your drinking water have fluoride in it? YES NO I DON'T KNOW

What Township do you live in? _____

Lead Poisoning Risk:

Does your child live in or regularly visit a house built before 1978?
YES NO

Does the child have a sibling/friend/family member with a confirmed elevated blood lead level?
YES NO

Does the child live with an adult whose job/hobby involves exposure to lead?
YES NO

In the past 12mths, has the child moved in to Chester County from (or recently spent 1mth) a foreign country or major city/metropolitan area?
YES NO

Social History:

Recreational Drug Use (Family or Personal): Current / Past / Never
Smoking (Family or Personal): Current / Past / Never
Alcohol (Family or Personal): Current / Past Never

Family History:

FATHER: **Living:** **Age** _____ **Deceased: Age** _____

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid Disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	

Arthritis **High blood Pressure** **Diabetes 1 or 2** **Thyroid Cancer**

Other: _____

MOTHER: **Living:** **Age** _____ **Deceased: Age** _____

Alcoholism **Blood Cancer** **Migraines** **Bipolar** **Osteoporosis**

COPD/Emphysema **Skin Cancer** **Colon Cancer** **High Cholesterol**

Stroke **Heart Disease** **Lymph Cancer** **Thyroid Disorder**

Anemia **Asthma** **Breast Cancer** **Dementia**

Blood Clot/DVT **Depression** **Kidney Disease** **Prostate Cancer**

Arthritis **High blood Pressure** **Diabetes 1 or 2** **Thyroid Cancer**

Other: _____

Siblings: _____

_____

List other Medical Providers you see on a regular basis (i.e. Cardiologist, Urologist, Mental Health, etc.)

_____

Patient or Guarantor's Signature:_____