



Ennis Pediatric and Adolescent Health Care Center, P.A.

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PATIENT MEDICAL HISTORY

PATIENT NAME	DATE OF BIRTH
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BIRTH HISTORY

COMPLICATIONS DURING PREGNANCY? IF YES, PLEASE SPECIFY		
DELIVERY TYPE <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarian	IF CAESARIAN, WHY?	
GESTATIONAL AGE	BIRTH WEIGHT	BIRTH LENGTH
HEARING SCREEN <input type="checkbox"/> Passed <input type="checkbox"/> Failed <input type="checkbox"/> Not Done		

TREATMENT HISTORY

HOSPITALIZATIONS (DATES AND REASON)
SURGERIES (DATES AND REASON)
SPECIALISTS SEEN
MEDICATIONS

CHRONIC MEDICAL PROBLEMS (Check all that apply)

<input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Eczema <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Asthma <input type="checkbox"/> Constipation <input type="checkbox"/> Heart Disease <input type="checkbox"/> Problems with Menstrual Cycles	<input type="checkbox"/> Allergies (seasonal, medications, food) <input type="checkbox"/> Developmental Delay (please specify) <input type="checkbox"/> Other (please specify)
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FAMILY HISTORY (Check all that apply and list family members with medical condition)

<input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer
<input type="checkbox"/> Eczema
<input type="checkbox"/> Allergies (seasonal, medications, food)
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Crohn's Disease, Irritable Bowel Disease
<input type="checkbox"/> Mental Illness (Depression, Anxiety, Bipolar Disorder, Schizophrenia)
<input type="checkbox"/> Other (please specify)