Julie Ralls, M.D.
2011 Westcliff Dr., Suite 4
Newport Beach, CA 92660

CONFIDENTIAL PATIENT HISTORY- Pediatric

Name____
Date of Birth_______________________________________

Past Medical History

Has your child ever had any major medical problems? If so, please describe. ____________
____
____
____
____

Has your child ever had any surgeries? Please list, including dates.____________________
____
____
Any major accidents or injuries?____
Has your child ever been hospitalized any time other than the above, or at birth? Please list, including dates.____
____

Were there any problems with this child during pregnancy or at birth?____________________
____

Was this child born vaginally, or by cesarean section, and if the later, why?________________
____

What medications is your child currently taking? Please list dosages if possible, and any over-the-counter remedies, vitamins or herbs.____
____
____
Has your child ever had any negative reactions to medications? Please explain._______________
____
____

Do any blood relatives have any major medical problems? If so, please list._________________
____
____
____

Was this child breast fed?_____For how long?_______________________________________

Are your child's immunizations up to date?__Please bring a copy of vaccination records for our chart if possible.

<OVER>

Does your child smoke or is your child exposed to smokers?______________________________
____
Has your child ever abused drugs or alcohol? ____
What are your child's hobbies or interests?____
____
Does this child have a religious or spiritual support system or community in his or her life?______
____
Do you have pets?____
How often does your child exercise and what type of exercise does he or she do?______________
____
Does the child sleep well?____
Would you say this child has a healthy, well-rounded diet?___________________
What do you consider to be major events that have happened in this child's life, i.e. divorce, serious accident, death of a loved one, lottery win, trips around the world, etc. ________________________
____
____

Is there anything else in particular that you think your doctor should know or that you would like to discuss with the doctor today?____
____
____

For Female Patients Only, please answer where applicable:
How many times total have you been pregnant?____
How many live babies have you had?____
What happened with the other pregnancies?____
____
How old were you when you had your first child?____
How old were you when you had your first period?_______________________________________
Do you have irregular or painful periods?____
Did you breast feed your children?____
Are you pregnant or nursing now?____
When was your last menstrual period?____
When was your last pap smear?__________________________Was it normal?__________________
When was your last clinical breast exam?____
Do you do a self breast exam monthly?____
Do you use birth control?____
Do you have any questions about sexuality or birth control?__________________________________

For Male Patients Only:
Do you do a monthly testicular self-exam?____
Do you have any questions about sexuality or birth control?__________________________________

Name of person completing this form____
Signature____
Date____