

THOMAS R. VECCHIONE, M.D.
3399 FIRST AVENUE
SAN DIEGO, CA 92103

PEDIATRIC HISTORY

Name: _____ Date: _____

Complications at Birth: _____

Feeding Problems: _____

FAMILY HISTORY

(Circle if yes, indicate family member)

Allergies / Asthma / Eczema

Heart Disease / High Blood Pressure

High Cholesterol

Diabetes / Thyroid Disease

Cancer

Birth Defects

ILLNESS

(Has your child ever had?)

Asthma / Bronchitis / Pneumonia

Eczema / Hay Fever

Infectious Mono

Ear Infections

Kidney / Bladder Infections

Immune Deficiency Syndrome

Chicken Pox (Age: _____)

Bleeding Problems

Heart Defect

REASON FOR VISIT TODAY _____

PREVIOUS HOSPITALIZATIONS AND SURGERIES:

(Give date, age and reason for the hospitalization or surgery)

MEDICATION ALLERGIES: _____

ANY OTHER ALLERGIES: _____

CURRENT MEDICATION: _____

Primary Care Physician: _____

Referring Physician: _____