

# Boulevard Pediatrics

## *Patient Medical History*

Child's Name (First, Middle, Last)

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Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Please list patient's ongoing medical problems: \_\_\_\_\_

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Please list any specialists patient has seen: \_\_\_\_\_

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Please list patient's surgical procedures, serious injuries and reasons for hospitalization: \_\_\_\_\_

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Please list all of patient's allergies: \_\_\_\_\_

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Are patient's vaccinations up-to-date: \_\_\_\_\_yes \_\_\_\_\_no