CHILDREN'S MEDICAL GROUP
500 GREENE STREET CUMBERLAND MARYLAND 21502
PATIENT DEMOGRAPHIC SHEET

Date completed: _____ Referred By: _____

Patient's Name:_____ Sex: Male_____ Female_____
Date of Birth: _____ Race: _____
Address: _____
Home Telephone: _____ Cell Phone: _____

Mother's Name: _____ Employer: _____
Cell Phone: _____ Work Telephone: _____
Additional information _____

Father's Name: _____ Employer: _____
Cell Phone: _____ Work Telephone: _____
Additional information _____

Parents: (circle one) Married; Not married, living together; Not married, not living together
Deceased

Child's Health Insurance Coverage: _____

Emergency Contact : _____ Phone:_____

Child's Health History

Duration of pregnancy _____
Delivery type: Vaginal☐ C-section☐
Birth Weight _____
Birth Place _____
Obstetrician _____
Pediatrician _____
Feeding: Breast _____ Bottle _____
Formula type _____
Vaccine Reactions _____
Drug Allergies _____
Food Allergies _____
Other Allergies _____
Date of Chickenpox illness _____
History of Seizures _____
History of Asthma _____
Frequent Ear Infections _____
Hospitalizations _____
_____
Developmental Delays _____
_____
Any significant injuries _____
Any surgical procedures _____
Current Medical Problems _____
_____
Current Medications _____
_____
Please describe any other issues or concerns _____
_____

(PLEASE TURN OVER TO COMPLETE OTHER SIDE)

School
Present grade in school _____ Name of School _____
Academic performance _____
Behavior (describe) _____

Home
Does anyone in the household smoke? _____
Type of home heating _____
Do you have pets in the home and what kind? _____
Do you have guns in the home? _____
If yes, are the guns housed in a secure location? _____

Child Care
Does the child attend day care? Yes ☐ No ☐
Name of Day Care Provider _____

Family History

Relationship to Child:	**Name**	**Current Age**	**Current Health**
Mother			
Father			
Sib			
Sib			
Sib			
Sib			

Number of Pregnancies (include miscarriages/abortions) _____
Other pertinent family history _____

Family Medical History
(Include: Child's Grandparents, Uncles, Aunts, and First Cousins)

Heart Disease before age 55 _____
Asthma _____
Other lung disease _____
Allergies _____
Seizures _____
Behavior Problems _____
Mental Illness _____
Diabetes – childhood onset _____
Diabetes – adult onset _____
High blood pressure _____
Kidney disease _____
Birth defects _____
School Problems _____
Mental Retardation _____
Other: _____

Please return this form to your child's doctor for review.