Takashi Yoshida MD, Inc

Pediatric History	Date:

Patient Name: ______________________________________ M/F Birthdate:________________________

Hospital Born:____

Type of Delivery: Term: Labor: APGAR: Blood Type:

Birth Weight: Birth Length: Jaundice: Circumcision: Y/N

Family Members	DOB	Blood Type	Medical History	Relative Family History
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				

Feeding/Nutrition	Age	Past History: Please circle and sate if your child has had any of:	
Breast Feed		Roseola	
Formula		Measles	
Baby Food		Rubella	
Cow's Milk		Mumps	
		Chicken Pox	
Vitamins		Pertussis	
Fluoride		5th Disease	
Allergies		Pneumonia	
		Severe Diarrhea	
Milestones		Hand,Foot,Mouth Disease	
Held Head Up		Allergic Conjunctivitis	
Sat Alone		Atopic Dermatitits	
Crept/Crawled		Acute Gastroenteritis	
Walked		Urinary Tract Infection	
First Words		Acute Otitis Media	Food Poisoning
Sentences		Allergic Rhinitis	Asthma
Teeth		Febrile Seizure	Sinusitis
Toilet Trained		Allergy to Food	
		Allergy to Medication	
		Injury : Laceration	
		Fracture	
		Hospitalization	

In the event I_________________________________, cannot be reached by phone to discuss my child's illness, x-ray reports, laboratory results or treatment, I hereby authorize Takashi Yoshida, MD to leave a detailed message at my home or cell phone.

Parent/Guardian Signature:__________________________________ Date:__________________