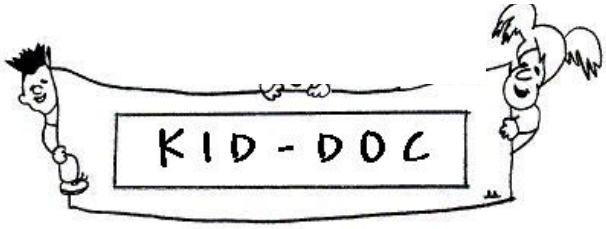

PEDIATRICS

Dr. Shahzad A. Sheikh, M.D., F.A..A..P
Pediatric and Adolescent Med

Name: _____ Date of Birth: _____ Male or Female

Please circle all answers

1. - Are you allergic to any medication? Yes / No
   If so, please list _____

2. - Are you currently taking any medication? Yes /No
   If so, please list _____

3. - Have you had any injuries/surgeries? Yes/No
   If so, please list description, dates and place: _____
   _____
   _____

4. - Smokers inside of the house? Yes/No Outside of the house? Yes/ No
   Alcohol Yes/No How often? _____

5. - Patient lives with: Mom Dad Stepparent Grandparents Other

6. - Does patient have problems with the following:
   -Behavior/ interaction with peers? Yes/No - School Performance? Yes/No

Parent's signature: _____ Today's date: _____

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