El Paso Pediatric Associates, P.A.

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PATIENT RECORD

Name _____ Birth Date_____ Male/Female_____ Blood type _____
Father's Name_____ S.S.#_____ Phone( )_____
Mother'sName_____ S.S.#_____ Phone( )_____
Father's Address_____ City_____ State_____ Zip_____
Mother'sAddress_____ City_____ State_____ Zip_____
Child's S.S.#_____ Referred by:_____
Father's Employer _____Phone( )_____
Mother's Empoyer_____Phone( )_____
Insurance Carrier_____Ins. ID#_____

FAMILY HISTORY

	AGE	HEALTH	ALLERGIES OR OTHER PROBLEMS
Mother			
Father			
Children			

PAST HISTORY

PCP_____Hosp._____Gestation_____Birth Wt._____Length_____
Condition/Complications at Birth_____
_____
Hospitalizations_____
_____
Drug Allergies_____
_____
Reactions to Immunizations_____
Any Additional Concerns_____

PLEASE DO NOT FILL BELOW **OFFICE USE ONLY**

IMMUNIZATIONS

VACCINE	VIS DATE	1ST	2ND	3RD	4TH	BOOSTER	BOOSTER	
HEP-B	(07-18-07)							
DTAP	(05-17-07)							
IPV	(01-01-00)							
HIB	(12-16-98)							
PCV7	(09-30-02)							
ROTAVIRUS	(04-12-06)							
MMR	(01-15-03)							
VARIVAX	(01-10-07)							
HEP -A	(03-21-06)							
TDAP	(07-12-06)							
MCV4	(01-28-08)							
HPV	(02-02-07)							
PPD								
FLU	(current yr)							