ELIZABETH B WHITE M.D.
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COVINGTON, LA 70433
985-871-8681 FAX 985-871-8684

PEDIATRIC FORM:

NAME: _____**DATE** _____

AGE: _____ **REASON FOR VISIT:** _____

REFERRED BY: _____

BIRTH HISTORY:

FULL TERM / PREMATURE

BIRTH WEIGHT: _____

ANY COMPLICATIONS? _____

PAST MEDICAL HISTORY: (PLEASE CIRCLE)

ASTHMA	ECZEMA
HEART MURMUR	SEIZURES
FREQUENT EAR INFECTIONS	PNEUMONIA
FREQUENT STREP THROAT	ALLERGIES

PAST SURGICAL HISTORY:
ANY OPERATIONS? _____

FAMILY HISTORY:

	MEDICAL PROBLEM	AGE AT ONSET
MOM	_____	
DAD	_____	
SIBLINGS	_____	
	_____	
	_____	

SOCIAL HISTORY:

PARENTS: MARRIED / DIVORCED

ANY SIBLINGS AND AGES _____

SCHOOL _____

TOBACCO USE IN HOUSE: YES / NO **PETS IN HOUSE:** YES / NO