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PATIENT INFORMATION FORM

Please take a few minutes to complete the following information so that we may better provide for your family's medical needs. Please complete all pages and answer all questions as much as possible. Due to the nature of our work we do not bill insurance. You will be supplied with the necessary paperwork to process your own insurance claim upon payment. All appointments not cancelled at least 48 hours in advance will be charged a non-cancellation fee.

DATE: ___________________________

PATIENT'S NAME: ____
DATE OF BIRTH: ___________________________SEX:_________
PERMANENT ADDRESS: ____
____
LOCAL ADDDRESS (if different): ____
____
TELEPHONE NUMBERS: ____
EMAIL(S): ____
FATHER'S NAME: ____AGE:_______
EMPLOYER: ____
ADDRESS: ____
WORK TELEPHONE: ____
TYPE OF WORK: ____
MOTHER'S NAME: ____AGE: _____
EMPLOYER: ____
ADDRESS: ____
WORK TELEPHONE: ____
TYPE OF WORK: ____
CHILD LIVES WITH: ____
NAME AND TELEPHONE OF EMERGENCY CONTACT: ________________________

Please indicate how you were referred: ____
____
____

MEDICAL INFORMATION

NAME OF PATIENT: ________________________________Allergies__________________________

FAMILY MEDICAL HISTORY

NAMES AND AGES OF ALL SIBLINGS: ____

____

Please list all family members, including the natural mother and father, grandparents, aunts, uncles, first cousins, brothers and sisters who have any chronic or serious illness or conditions of any kind, including those related to conditions of this child. In addition, if there are any known inherited conditions that have occurs in any family member, however related, please list.

Relation to patient	Condition or disease	Current age	Age condition began

PLEASE CHECK HERE ( ) AND CONTINUE ON THE BACK IF NECESSARY.

PRENATAL AND BIRTH HISTORY

1. Is the patient adopted? ______________
2. At birth, what was the mother's age? _______ father's age: _______
3. How many pregnancies did the birth mother have prior to this one and were they full term, premature pregnancies or miscarriages/abortions:_____________________________________
4. How many weeks was the birth mother pregnant (40 weeks is the due date)? _____________
5. What type of delivery (e.g. vaginal, cesarean, vacuum, etc.) ______________________?
6. If other than vaginal, why? _______________________________________
7. What anesthesia or pain medicines used during labor or delivery? _______________________
8. Were treatments used to start (induce) or strengthen contractions? _______________________
9. Were any antibiotics given during labor, delivery, or after delivery (include details)? ________
   ____
10. Place of birth: _____________________________________
11. How long was the baby in the hospital (if applicable)? __________________________________
12. Measurements at birth: weight _________ length: __________
13. During the first month of life did the baby have any illnesses or problems, take medicines or have any tests other than routine tests (include details)? ______________________________________
14. During the pregnancy were there any illnesses or treatments (include details)? ________________
    ____
15. Has the birth mother ever during her life had any vaginal infections (include details)? __________
    ____
16. What other physical, emotional, dental or other stressful ailments or conditions have occurred during the birth mother's life? ____
    ____
17. What vitamins and/or other nutritional supplements were taken during the pregnancy? _________
    ____

DIETARY HISTORY

1. How long did the patient breast feed? _____________________

2. During breastfeeding did the mother experience any breast related problems, including sore nipples, plugged ducts, breast itching/pain or mastitis (include details)? _________________
____
3. What formulas did the patient take and at what ages? ___________________________________
4. When did he/she begin solid foods? ________________________
5. What vitamins or nutritional supplements is the patient taking? ___________________________
6. Please describe the current diet: ____
____
____
7. How much water does he/she drink daily? __________________
8. List foods he/she craves: ____
9. How often does he/she have a bowel movement? _____________________
10. What are the bowel movements like? ____
11. Describe any symptoms related to any particular foods: ___________________________________
____

MEDICAL HISTORY

1. List and describe any hospitalizations: ____
____
2. Describe any accidents, falls or other injuries: ____
____
3. List and describe any surgeries: ____
4. Childhood illness and year(s) (e.g. chicken pox, measles, mumps, rubella): __________________
5. How many ear infections? _______
6. How many throat infections treated with antibiotics? ______
7. How many episodes of pneumonia or bronchitis (details): ________________________________
8. Has he/she ever been treated for thrush or other fungal infections or been treated with antifungal medications by mouth or on the skin? ___________________________
9. Are there any other illnesses that are a concern to you (include details)? __________________
____
10. Are his/her vaccines/immunizations current? _______If not, how many has he/she received?_____
11. Has he/she or any family member had reactions to any vaccines? _______________________
12. Please list all medications he/she is taking: ____
____
13. Does anyone smoke anywhere around the patient? __________
14. Have there been any concerns related to either growth or development (speech, motor, etc.) _______ (detail on the back of this page)

Dr. Rydland strives to provide you with complete medical evaluations and appropriate treatment options for all of your children's medical conditions. We want to do all we can to restore vibrant health and not just focus on eliminating disease. To do so we need to have regularly updated information about your child's change(s) in condition and recommendations of other treating practitioners. Please have any specialists or other practitioner's forward information regarding their evaluations and proposed treatments or send us this information yourself. Dr. Rydland is available for telephone calls after regular office hours, but will either need to see your child or do a telephone consultation regarding some more involved conditions. There is a charge for some telephone consultations and an additional charge for office visits performed outside of our normal business hours. I understand that fees are based upon time and type of service. If I have questions about fees I will address them before seeing the doctor.

Not all medical services are covered by medical insurance. Although we recommend you contact your insurance company prior to any medical treatments or tests, it is important to understand that insurance companies may later deny coverage for any of these. We do our best to supply you with the necessary information to bill your insurance, but cannot be held responsible for the errors of the insurance companies.

Signature ____ Date: _____________________