Lexington Pediatrics, P.C.

Pediatric and Adolescent Medicine

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EMR Patient Sheet

Patient Name____
Date of Birth____
Date of Next Visit (if known) ____

Does your child have any chronic medical issues? If yes, please list below.

____
____

Has your child ever seen a specialist for any reason? If so, please list provider's name(s) and reason for visit(s).

____
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____
____

Current Medications: Please provide name, dose and frequency (if you know it).

____
____
____

Food Allergies:____

Drug Allergies:____

Has your child had any surgery? If yes, please provide surgeon's name, date and type of operation. _
____
____

Has your child ever been admitted overnight to a hospital? If yes, please provide the dates and reasons. ____
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Please add the below information for your principal pharmacy:
Pharmacy Name:____
Address:____
City:______________________________ State:_____________________ ZIP:______________
Phone:____