Name of Patient: Name of Street: Name of Town: Phone/Fax:	Date of birth: Name of Mother/Father:

Please report any changes of address or phonenumber.
Please hand us the booklet of vaccinations and the yellow book of the childs routine examinations

Which schoolclass / kindergarden is your child visiting?

Former pediatritcian:

Are there any illnesses of relevance known from the past?	
Is there any medication taken frequently? Yes ☐ No ☐	**If yes, please list:**
Are there any reactions to medication? Yes ☐ No ☐	**If yes, please list:**
Are there allergies known? Yes ☐ No ☐	**If yes, please list:**
Have there been any surgical treatments? If yes please list:	
Actual problems – intent of visit:	

Please answer the following questions:

Name of father:	Name of mother:	Sibling	Sibling
Fathers employment:	Mothers employment:		
Problems with vision in Childhood? yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
Problems with the hips in Childhood? yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
Chronic disorders?			