Medical History

Patient Name: _____ **DOB:**_____

Personal Medical History:

Has your child ever been involved in a serious injury or accident? ☐ No ☐ Yes
If yes, when and why? _____

Has your child ever had surgery? ☐ No ☐ Yes
If yes, when and what procedure? _____
_____

Has your child ever stayed overnight in a hospital? ☐ No ☐ Yes
If yes, when and why? _____
_____

Please check if your child has had any of the following medical problems:

- ☐ Chicken Pox
- ☐ Frequent Ear or Sinus Infections
- ☐ Pharyngitis/Tonsillitis
- ☐ Other Infectious Illnesses
- ☐ Allergic Rhinitis or other Allergy:
  - ☐ Animal Allergens
  - ☐ Outdoor Allergens
  - ☐ Indoor Allergens
- ☐ Asthma, Bronchiolitis, Pneumonia, or Croup
- ☐ Heart Problems or Heart Murmur
- ☐ Abdominal Pain/ GER
- ☐ Constipation requiring doctor visits
- ☐ Frequent Urinary Tract Infections
- ☐ Bed-wetting (after 5 yrs of age)
- ☐ Eye Conditions/Corrective Lenses
- ☐ Problems with Ears or Hearing
- ☐ Chronic or Recurrent Skin Problems (Acne, Ezcema, etc)
- ☐ Anemia or Bleeding Problems
- ☐ Blood Transfusion
- ☐ Frequent Headaches
- ☐ Seizures
- ☐ Developmental Delays
- ☐ ADD/ADHD
- ☐ Mental Health Concerns
- ☐ Orthopedic Concerns
- ☐ Diabetes
- ☐ Thyroid or other Endocrine Problems
- ☐ If Female and menstrual periods have started, any problems with periods?

Social History:

Who lives at home? (including pets) _____
_____

Does anyone in your home smoke? ☐ No ☐ Yes

Are there any guns in the home? ☐ No ☐ Yes
If yes, are guns locked and kept separate from ammunition? ☐ No ☐ Yes

Continue on Back

Family Medical History:

Please check mark if your child has a family history of any of the following:

Diagnosis	**Natural Mother**	Natural Father	Sister	Brother	Half-Sister	Half-Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergies										
Asthma/ Lung Disease										
Heart Disease/ Condition										
High Blood Pressure										
High Cholesterol										
Diabetes or Other Endocrine Problems										
Cancer, what type?										
Anemia										
Bleeding Disorders										
Epilepsy or Convulsions										
Developmental Disorders										
Neurological Disorders (including ADD/ ADHD)										
Liver Disease										
Other GI Disease/ Disorder										
Kidney Disease										
Bed-wetting (after 10 yrs of age)										
Hearing Impairment										
Vision Impairment or Eye Disorder										
Immune Problems, Recurrent Infections, or HIV/AIDS										
Alcohol Abuse										
Drug Abuse										
Mental Illness										
Tuberculosis										
Obesity										
Other										