Medical History Form

For patients 3 years and Older

Todays Date: _____

Patient's First/Last Name: _____ **Date of Birth:** _____

Eye Doctor: _____

Dentist: _____

This form is necessary to provide the "complete picture" of your child's health to your provider. By gathering this information, it allows your provider to offer the best care possible for your child(ren).

Patient's Past Medical History - Please Print

1. Please list any previous hospitalizations (list month/year, hospital and reason for hospitalization ☐ NONE

_____

2. Please list any previous surgeries (list month/year, hospital and surgery performed) ☐ NONE

_____

3. Please list any serious injuries or accidents (list month/year and nature injury/accident) ☐ NONE

_____

4. Are there any drug or food allergies? ☐ YES ☐ NO (If yes, please list below with reaction)

_____

5. **For girls:** Has she started her menstrual periods? ☐ YES ☐ NO Are there problems with her periods?

_____

Please **CHECK** any conditions your child currently has or has had in the past:

- ☐ Chicken pox
  If yes, When? _____
- ☐ Eye Conditions/Corrective Lenses
- ☐ Frequent ear or sinus infections
- ☐ Problems with ears or hearing
- ☐ Frequent pharyngitis or tonsillitis
- ☐ Allergic Rhinitis or other allergy
- ☐ Indoor allergens: _____
- ☐ Outdoor allergens: _____
- ☐ Asthma
- ☐ Frequent bronchitis, bronchiolitis, or pneumonia
- ☐ Recurrent Croup
- ☐ Other Chronic/serious lung diseases
- ☐ Tuberculosis or positive TB test
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Congenital/acquired heart defect
- ☐ Anemia or bleeding problem
- ☐ Blood Transfusion
- ☐ Frequent abdominal pain or GERD
- ☐ Constipation requiring doctor visits
- ☐ Bladder, kidney infection or other urologic problems
- ☐ Bed-wetting (after 5 years old)
- ☐ Thyroid or other endocrine problems
- ☐ Diabetes
- ☐ Chronic or Recurrent skin problems (acne, eczema, etc)
- ☐ Frequent headaches
- ☐ Seizures or other neurologic problems
- ☐ Developmental delay or disorder
- ☐ Behavior disorder (ADHD, ODD, other)
- ☐ Mental health concerns or disorder
- ☐ Emotional problems or suicide attempts
- ☐ Use of alcohol or drugs
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Sexually transmitted infection
- ☐ Orthopedic problems

Please explain any conditions you checked above or any other significant medical problems:

_____

_____

_____

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Family History - Check all that apply. **ONLY** include **GENETIC** family members.

Leave blank if the child is a foster child, adopted, or if the biological parents are unknown.

	Mom	Dad	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Asthma/Other Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐
Nasal/Other Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes or Other Endocrine Problems (Before 50)	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease (Before 50)	☐	☐	☐	☐	☐	☐	☐	☐
Rheumathologic Disease (Arthritis, Lupus, Thyroid Disease)	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Developmental Delay/Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy, Convulsions, or Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Neurological Disorder	☐	☐	☐	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Problems/Deafness	☐	☐	☐	☐	☐	☐	☐	☐
Vision Impairment/Eye Disorder (Not Including standard glasses or contacts)	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Bed-wetting (after 10 years old)	☐	☐	☐	☐	☐	☐	☐	☐
Immune Problems, Recurrent Infections or HIV/AIDS	☐	☐	☐	☐	☐	☐	☐	☐
Milk and/or Soy Intolerance	☐	☐	☐	☐	☐	☐	☐	☐
Other GI Disease/Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Unexplained Sudden Death (Before 50)	☐	☐	☐	☐	☐	☐	☐	☐

Additional Pertinent Conditions:

_____

_____

_____

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Developmental History - Please Print

1. Is there any Significant medical history pertaining to your child's birth or development? ☐ YES ☐ NO
   If yes, please describe _____
2. Is child in school ☐ YES ☐ NO
3. Does your child have any difficulties in academics? ☐ YES ☐ NO
4. Is he/she in special resource class? ☐ YES ☐ NO
5. Has he/she failed or repeated a grade? ☐ YES ☐ NO
6. Has he/she been diagnosed with a learning disorder? ☐ YES ☐ NO

Social History - Please Print

List the names of those **LIVING IN THE HOUSEHOLD** - include any parents, siblings, extended family, step-family, grandparents & others.	**Date of Birth**	**Relationship to Child**

1. Parents' Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Other
2. If parents are not living together or if the child does not live with parents, what is the child's custody status?
   _____
3. What is the visitation status of any non-custodial parents(s)?
   _____
4. Parents' Name/Occupation: _____
5. Parents' Name/Occupation: _____
6. Daytime Status: ☐ Home ☐ Daycare ☐ School
7. Does anyone in the household smoke ☐ YES ☐ NO
8. Does anyone at daycare smoke ☐ YES ☐ NO ☐ Not Applicable
9. Are there pets in home ☐ YES ☐ NO
10. Are there pets in the daycare ☐ YES ☐ NO ☐ Not Applicable
11. Are there firearms in the home? ☐ YES ☐ NO
12. Are the guns locked and kept separate from ammunition? ☐ YES ☐ NO ☐ Not Applicable

IN CASE OF AN EMERGENCY - PLEASE LIST CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE: _____

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