Confidential Medical History Form for Children

Please bring this completed form to your child's office appointment

Name: _____ DOB: _____ Today's Date:_____

Birth History for Patient:

Was the pregnancy full term? Y or N
Were there complications with the pregnancy or delivery? Y or N
Did you go home in 24 - 48 hours? Y or N
If not why? _____
How much did your child weigh at birth? _____

Past Medical History: Has the child had any of the following Conditions?

□ Abdominal problems?
□ Any serious injury?
□ Asthma?
□ Behavior Problems?
□ Broken Bones?
□ Chronic Cough?
□ Constipation?
□ Frequent Temper Tantrums?
□ Hay fever/Sinus Problems?
□ Hearing Problems?
□ Heart Problems?
□ Joint/Bone Problems?
□ Kidney or Bladder infections?
□ Many ear infections?
□ Over Weight?
□ Pneumonia?
□ School Problems?
□ Seasonal Allergies?
□ Seizures?
□ Skills are behind other kids?
□ Underweight
□ Vision Problem?
□ Other? _____

Any Allergies to Medications?_____
Any Medications/Supplements taken frequently? _____

Social History:

Child has how many sisters? _____Brothers? _____
Grade in school/Preschool _____
Usual Grades received? _____ (A,B,C's, Etc.)
Is your child in daycare/after school care? _____
Who lives in your home? _____

Exposures:

□ Is there a smoker in the home/at babysitter's?
□ Do you always use seatbelt or car seat in your vehicle?

Family History: Has any blood relative of your child had...

□ Alcoholism?
□ Allergies?
□ Asthma?
□ Bleeding Disorder?
□ Blood Clots?
□ Cancer?
□ Deafness?
□ Depression?
□ Diabetes?
□ Drug Addiction?
□ Heart Problems?
□ Heart Vessel Surgery?
□ High Blood Pressure?
□ High Cholesterol?
□ Lung Disease?
□ Mental Illness?
□ Seizures?
□ Strokes?
□ Tuberculosis (TB)?
□ Other conditions?

Parents Signature: _____