Medical History Form

New patients 3 years & older

Patient's First/Last Name: ____ Birthdate ___________________

Age_________ Date form completed _________________

Please list the following: (Nurses, please enter under the "Basic Information" tab)

Primary Language:

Race: Declined to specify (circle)

Ethnicity: Declined to specify (circle)

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 of injury/accident) ☐None
   ____
4. Any drug or food allergies? ☐Yes ☐No (if yes list below with reaction)
   ____
5. **For girls**: Has she started her menstrual periods? ☐Yes ☐No
   Are there problems with her periods? ☐Yes ☐No
6. Does your child have any special communication needs? ☐Yes ☐No (If yes, please explain below)
   ____
7. Does your child see a dentist? ☐Yes ☐No If yes, who: ________________________
   Date of last visit: ________________

Please **CIRCLE** any condition 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 disease

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 problem

Bed-wetting (after 5 years old)

Thyroid or other endocrine problem

Diabetes

Chronic or recurrent skin problem (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 problem

Please explain any conditions you circled above or explain any other medical conditions:

____

____

____

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____

Patient's First/Last Name: ____ Birthdate ______________________

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 years old)								
High Blood Pressure								
High Cholesterol								
Heart Disease (before 50 years old)								
Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)								
Kidney Disease								
Liver Disease								
Anemia								
Bleeding Disorder								
Developmental Delay/Disorder								
Mental Illness								
Epilepsy, Convulsions, or Seizures								
Neurologic 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 years old)								

If no significant family history, please check here: ☐

Additional Pertinent Conditions

Explain ____

Patient's First/Last Name: ____ Birthdate ____________________

Patient Developmental/Academic & Social History

Daytime Status: ☐Home ☐Daycare ☐School

1. Is there any significant medical history pertaining to your child's birth or development?

☐Yes ☐No If yes describe) ____

2. Has your child have any difficulties in academics? ☐Yes ☐No ☐Not applicable

3. Has he/she been placed in a special resource class? ☐Yes ☐No ☐Not applicable

4. Has he/she failed or repeated a grade? ☐Yes ☐No ☐Not applicable

5. Has he/she been diagnosed with a learning disorder? ☐Yes ☐No

6. Has your child displayed any signs of social isolation or social anxiety? ☐Yes ☐No

7. Has your child experienced any issues with bullying? ☐Yes ☐No

If you marked "yes" to 5 or 6, please hand your form directly to the nurse or to the provider that is seeing your child today

Please explain any "yes" answers further:

____

____

Household Structure

List the name of those LIVING IN THE HOUSEHOLD- include any parents, siblings , any 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 parent(s)? ______________________
____

4. Parent's Name/Occupation: ____

5. Does anyone in the household smoke? □Yes □No

6. Does anyone at daycare smoke? □Yes □No □Not applicable

7. Are there pets in the home? □Yes □No
If yes, what type of pets? ______________________________

8. Are there pets in the daycare? □Yes □No □Not applicable
If yes, what type of pets? ______________________________

9. Are there firearms in the home? □Yes □No
If yes, are the guns locked and kept separate from ammunition? □Yes □No □Not applicable

10. In the last year, have you worried that the food you purchased would run out before you had money to buy more?
□Yes □No □Declined to Answer

11. In the last year, did you run out of food and not have money to purchase more?
□Yes □No □Declined to Answer

If you answered **yes to the two questions above**, would you like information on community resources that can help? □Yes □No