Medical History Form
New patients 3 years & older

Patient's First/Last Name: _____ Birthdate _____

Age _____ Date _____

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 any other significant medical problems:

_____

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)								

Additional Pertinent Conditions

Explain _____

_____

Patient's First/Last Name: _____ Birthdate _____

Patient Academic & Social History

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

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)?

   _____

Patient's First/Last Name: _____ Birthdate _____

4. Parent's Name/Occupation: _____

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