Medical History Child

Parent or guardian: Please fill out the following form to help us provide the best possible care to your child.
(Some questions may apply to a child older or younger than yours.)

PLEASE ANSWER THE QUESTIONS THAT APPLY TO YOUR CHILD.

Do you have an Optometrist (Eye Doctor): ___ YES ___ NO

Do you have a Dentist: ___ YES ___ NO

Do you have a Therapist/Counselor: ___ YES ___NO

Patient Information

Patient (Child) Name: ____ Date of Birth: _______________ Age: ____________

Mother's Name: ____ Father's Name: _________________________________

If Guardian is not mother/father, give name & relationship to child: ____

Who lives with the child? _________________________________ House or apartment? ______________ Year Built: ________

Immunizations

Last date of immunizations: ____________________________ Where: ____

Has the child had any reactions to immunizations in the past? YES NO

If yes, please specify: ____

Do you have a record of your child's shot history? YES NO If yes, please bring a copy to your child's next medical visit.

Past History

Has the child received regular medical care until now? YES NO If yes, who was the doctor?______________________

Has the child received regular dental care until now? YES NO If yes, who was the dentist?______________________

When was the child's last medical check-up? ______________________ Last dental check-up? _____________________

If less than 1 year old, do they sit in a rear-facing car seat? YES NO

If 1-4 years old, do they sit in a forward facing car seat? YES NO If 5-8 years old, do they sit in a booster sit? YES NO

Does the child have any personal habits that are a concern? (Thumb sucking, bed wetting, drug use, tobacco use)YES NO

If yes, please specify: ____

Does the child or your family have any religious beliefs that might affect medical care? YES NO

If yes, please specify: ____

Past Medical History – Has the child ever had the following: _____ Patient denies any past illness

	Condition	Dates
	Asthma	
	Allergies-Hay fever	
	Allergies-Other	
	Allergies-Other	
	Birth Defects	
	Bleeding Disorder	
	Cancer	
	Other Diseases	

	Condition	Dates
	Depression	
	Diabetes	
	Epilepsy/Seizures	
	Frequent Ear Infections	
	Frequent Urinary Tract Infections	
	Kidney Problems	
	Migraines	
	Other Diseases	

Past Surgical History – Has the child ever had the following: _____ Patient denies any past surgeries

Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred

	Condition	Dates
	Appendix	
	Ear Tubes	

	Condition	Dates
	Gallbladder	
	Tonsils/Adenoids	

	Condition	Dates
	Hernia Repair	
	Other	

Medications – Please list all medications the child is currently taking _____ Patient denies any medications

Current Medications	Dosage (mg)	How often per day

Allergies – Please list all food, medication, and environmental allergies _____ Patient denies any allergies

Family History – Has any blood relative had any of the following: (Leave blank if uncertain)

Patient denies family history of: _____ Breast Cancer _____ Colon Cancer _____GYN Cancer

Condition	Relationship to you
Cancer Type:	
Diabetes Type:	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Problem	

Menstrual History

Age of 1st period: _____ # of days between period: ______ Total days on period: ______ Date of last period: _______

Flow: _____ Light _____ Medium _____ Heavy Does child tend to clot: YES NO

Birth Control: YES NO Name of birth control: ____

Pregnancy History

Total number of pregnancies: _____ Full term pregnancies: _____ Premature Births: _____ Multiple births: _____

Terminated Pregnancies: _____ Miscarriages: _____ Ectopic pregnancies: _____ Living: _____

Social History

Tobacco: ___ Never ___Minimal ___YES (____ packs/day x ____ years) ____ QUIT _____ Years ago (____ packs/day x ____ yrs)

Alcohol: ___ Never ___Minimal ___ Less than 10 a week, ____ More than 10 a week, ____ QUIT _____ Years ago

Recreational Drugs: ___ Never ___Minimal ___ YES (____ packs/day x ____ years) ____ QUIT ____ Years ago (____ packs/day x ____ yrs)

Printed name of person completing this form: ________________________________Relationship to patient: _________________

Signature: ____ Date: _____________________