Frank R. Baum, MD Inc
200 Kalepa Pl, Kahului HI 96732

FAMILY HISTORY NAME : DOB:

Deafness	☐ Yes	☐ No	Who_____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who_____	Comments _____
Asthma	☐ Yes	☐ No	Who_____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who_____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who_____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who_____	Comments _____
High cholesterol	☐ Yes	☐ No	Who_____	Comments _____
Anemia	☐ Yes	☐ No	Who_____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who_____	Comments _____
Liver disease	☐ Yes	☐ No	Who_____	Comments _____
Kidney disease	☐ Yes	☐ No	Who_____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who_____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who_____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who_____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who_____	Comments _____
Drug abuse	☐ Yes	☐ No	Who_____	Comments _____
Mental Illness	☐ Yes	☐ No	Who_____	Comments _____
Mental retardation	☐ Yes	☐ No	Who_____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who_____	Comments _____
Additional family history	☐ Yes	☐ No	Who_____	Comments _____

PAST MEDICAL HISTORY

Does your child have, or has she/he ever had:

Chickenpox	☐ Yes	☐ No	When_____
Frequent ear infections	☐ Yes	☐ No	Explain_____
Problems with ears or hearing	☐ Yes	☐ No	Explain_____
Nasal allergies	☐ Yes	☐ No	Explain_____
Problems with eyes or vision	☐ Yes	☐ No	Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain_____
Blood transfusion	☐ Yes	☐ No	Explain_____
Frequent abdominal pain	☐ Yes	☐ No	Explain_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain_____
Bladder or kidney infection	☐ Yes	☐ No	Explain_____
Bed-wetting (after 5-years old)	☐ Yes	☐ No	Explain_____
(For girls) Has she started he menstrual periods?	☐ Yes	☐ No	Explain_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain_____
Any chronic or recurrent skin problem (acne, eczema, etc.)	☐ Yes	☐ No	Explain_____
Frequent headaches	☐ Yes	☐ No	Explain_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain_____
Diabetes,Thyroid or other endocrine problem	☐ Yes	☐ No	Explain_____
Any hospitalizations	☐ Yes	☐ No	Explain_____
Any other significant problem	☐ Yes	☐ No	Explain_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain_____