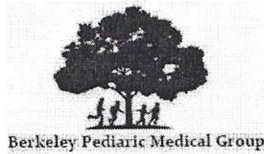


PATIENT MEDICAL HISTORY FORM

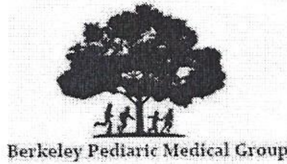
Date:	Name:	DOB:

BIRTH HISTORY		
Birth Weight:	Birthplace:	Any issues after birth?
Mom's Age:	During Pregnancy Did Mom:	Jaundice? Y N unknown
Premature? Y N	Smoke: Y N unknown	Feeding Problems? Y N unknown
Vaginal or Caesarean?	Drink: Y N unknown	Respiratory Problems? Y N unknown Other?
	Use other drugs or medications? Y N unknown	

MEDICAL HISTORY	Y	N	Explain
Has your child ever been hospitalized?			
Has your child ever had surgery?			
Any serious accidents or injuries?			
Any chronic medical conditions?			
Daily medications?			
Reactions to immunizations?			
Does your child have now, or have they ever had...			
Asthma or recurrent wheezing			
Eczema or other skin problems			
Allergic rhinitis or problems			
Recurrent ear infections or hearing concerns			
Problems with eyes or vision			
Frequent headaches or migraines			
Genetic or Metabolic disorders			
Gastrointestinal issues			
Growth or weight problems			
Bladder or kidney infections			
Heart problems, murmurs, high blood pressure			
Anemia or bleeding problems			
Endocrine issues (thyroid, diabetes)			
History of cancer			
Mental health issues (ADHD, anxiety/ depression)			
Any other medical conditions?			
Does your child see any specialists?			
Has your child received OT/PT/ Speech therapy?			
Seizures or other neurological problems?			
History of Concussions?			

Any other medical conditions not listed above? Please explain:

Reviewed by: ________________



FAMILY HISTORY QUESTIONNAIRE

Only one copy of this page needs to be filled out per family. We will scan a copy in each child's chart.

Date: ________________

Person Filling out this form: ______________________ Relationship to child: ______________________

PATIENT INFORMATION:

Child #1: ______________________________________ DOB: __________________ Male ☐ Female ☐ Other: ____________

Child #2: ______________________________________ DOB: __________________ Male ☐ Female ☐ Other: ____________

Child #3: ______________________________________ DOB: __________________ Male ☐ Female ☐ Other: ____________

Child #4: ______________________________________ DOB: __________________ Male ☐ Female ☐ Other: ____________

FAMILY HISTORY: PLEASE CHECK IF CHILD'S BIOLOGICAL RELATIVES HAVE ANY OF THESE CONDITIONS. USE THE BOTTOM OF THIS FORM IF EXTRA SPACE IS NEEDED.

	Y	N	Who was affected?	Explain
1. Allergies (Asthma, Eczema, Hay Fever, Food Allergies)				
2. Blood disorders (Bleeding, Clotting, Sickle Cell, Anemia)				
3. Bone/ Joint/ Rheumatic disorders (including hip problems in infants)				
4. Cancer (before 55 years old)				
5. High Cholesterol				
6. Diabetes (before 55 years old)				
7. Eye problems (blindness, lazy eye, crossing eyes)				
8. Ear problems (childhood hearing loss, hearing impairment, or hearing aid)				
9. Gastrointestinal Disorders (Celiac, Crohns, Ulcerative Colitis, GERD)				
10. Genetic disorders or Birth Defects (Cystic Fibrosis, Downs syndrome, Cleft Lip, Club Foot, Hip Dysplasia)				
11. Heart disease (Heart Attacks, arrhythmia) <65 years old for female, <55 years old for males				
12. Hypertension/ high blood pressure				
13. Infectious diseases or problems with immune system (HIV, Tb, Immunodeficiency)				
14. Kidney problems				
15. Nervous system disorders (migraines, seizures, epilepsy)				
16. Obesity				
17. Psychiatric conditions (Depression, Anxiety, ADHD)				
18. Thyroid problems				
19. Alcoholism or Drug dependence				
20. Regular Smoker				
21. Bed Wetting (older than 10 years of age)				
22. Other				

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Reviewed By:________________