Southwest Children's Clinic
Patient Medical History

Patient Name: _____ Date of Birth: _____

Has your child had any of the following? Please check any *past or current medical conditions*. **Please comment below on anything marked.**

- ☐ Serious injuries/accidents
- ☐ Surgeries
- ☐ Hospitalizations
- ☐ Chickenpox
- ☐ Frequent ear infections/sinus infections
- ☐ Pharyngitis/tonsillitis
- ☐ Other infectious illnesses
- ☐ Allergic rhinitis or other allergy
- ☐ Animals in the house
- ☐ Outdoor allergens
- ☐ Indoor allergens
- ☐ Asthma, bronchitis, bronchiolitis pneumonia or croup
- ☐ Heart problems/heart murmur
- ☐ Abdominal pain/reflux/heartburn
- ☐ Constipation requiring doctor visits
- ☐ Bladder or kidney infection or other urologic problem
- ☐ Bed-wetting (after 5 years of age)
- ☐ Eye conditions/corrective lenses
- ☐ Problems with ears or hearing
- ☐ Chronic or recurrent skin problems (acne, eczema, etc.)
- ☐ Anemia, bleeding problem or clotting disorder
- ☐ Blood transfusion
- ☐ Frequent headaches
- ☐ Seizures
- ☐ Developmental delays
- ☐ ADD/ADHD
- ☐ Other neurologic disorders
- ☐ Mental health concerns
- ☐ Muscle/bone/joint problems
- ☐ Diabetes
- ☐ Thyroid or other endocrine problems
- ☐ If female, have menstrual periods started?
- ☐ If female, any problems with periods?
- ☐ Use of alcohol or drugs
- ☐ Emotional problems
- ☐ Other significant problems

Comments: _____

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Family medical history:

Using the key given, please list any/all blood relatives (*in relation to the child*) who have had any of the following conditions:

MAT = Maternal
PAT = Paternal
MO = Mother
FA = Father
SIB = Sibling
AU = Aunt
UN = Uncle
CN = Cousin
GM = Grandma
GP = Grandpa
GGM = Great Grandma
GGP = Great Grandpa

Condition	Yes	No	Relationship
Nasal allergies, other allergies, eczema, etc.			
Asthma or lung disease			
Heart disease or heart condition			
High blood pressure			
High cholesterol			
Diabetes or other endocrine problem			
Cancer			
Anemia			
Bleeding disorders			
Epilepsy or convulsions			
Mental retardation or developmental disorders			
Neurologic disorder including ADHD/ADD			
Liver disease			
Other GI disease/disorder			
Kidney disease			
Bed-wetting (after 10 years of age)			
Hearing impairment			
Vision impairment or eye disorder			
Immune problems, recurrent infections, or HIV/AIDS			
Alcohol abuse			
Drug abuse			
Mental illness			
Tuberculosis			
Additional pertinent conditions			

Comments: _____

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Name of person completing form: _____

Signature: _____ Date: _____