Past Medical History

The following is **very important** to your child's health care. Please complete it **accurately** and **completely**.

Child's name____ Date of Birth______________________________

Which hospital was your child born?______________________________   Is child adopted/fostered? Y___N___

Patient-Medical History	No	Yes	Comments
Serious injuries or accidents			
Surgeries			
Hospitalizations			
Chickenpox			
Frequent ear infections			
Pharyngitis/tonsillitis			
Other infectious diseases			
Allergic rhinitis or other allergies			
Animal allergies			
Outdoor allergens			
Asthma,bronchitis,bronchiolitis,pneumonia,croup			
Heart problems or heart murmur			
Abdominal pain / reflux			
Constipation requiring doctor visits			
Bladder/kidney problems or other urinary issues			
Bed wetting (after 5 years of age)			
Eye conditions/corrective lenses			
Problems with ears or hearing			
Chronic or recurrent skin problems			
Blood transfusion			
Frequent headaches			
Seizures, developmental delays, ADD/ADHD, or other neurological problems			
Mental health concerns			
Orthopedic 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			

Social history	No	Yes	If No--Explain
Lives with both mother and father in same house			
Non-intact home-give custody status			
Visitation status of non-custodial parent			
Are there any siblings? (Names &Ages)			
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Guns locked and separate from ammunition?			

Family-Past Medical History	**No**	**Yes**	If **YES**—Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Fth	Maternal Gr Mth	Paternal Gr Fth	Paternal Gr Mth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Cancer									
Anemia									
Bleeding disorder									
Epilepsy									
Mental retardation or developmental disorder									
Neurological disorder, including ADD/ADHD									
Liver disease									
Other GI disease									
Kidney disease									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment									
Immune problems, recurrent infections or HIV/AIDS									
Alcohol abuse									
Drug abuse									
Mental illness									
Tuberculosis									
Additional pertinent conditions									

Is there anything else regarding your child's health that you think we should know that has not already been asked?____

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I attest that all of the medical history information is true and correct to the best of my knowledge:

Signature___________________________________ Relationship to patient_________________________

Print Name________________________________ Today's date__________________________________