Medical History

Patients Name: _____
DOB:_____

Is your child allergic to any drugs or medicines? ___Yes ___No Which ones?
_____

Any problems during the pregnancy or delivery for this child? ___Yes ___No Describe:
_____

Was this child born early? ___Yes ___No Gestational Age: _____ Birth Weight:_____

Was your child born or immunized outside of the USA? ___Yes ___No Where?
_____

Has your child ever had surgery? ___Yes ___No What for?
_____

Has your child ever been hospitalized overnight? ___Yes ___No Describe:
_____

Has your child ever had any chronic diseases? ___Yes ___No Describe:
_____

Has your child ever had any serious injury? ___Yes ___No Describe:
_____

Has your child been receiving any medicine or treatment for longer than 1 month? ___Yes ___No

Describe:_____
_____

Is there a smoker in the home? ___Yes ___No

Has your child ever had…

___ADHD/ADD or behavior problems ___Allergies /"hay fever" ___Asthma ___Birth defects ___Bladder

___Kidney problem ___Cancer ___Chickenpox ___Autism ___Depression ___Anxiety ___Diabetes

___Eczema ___Hearing problems ___Heart disease or problem ___High blood pressure

___Learning disability or problem ___Meningitis ___Obesity ___Pneumonia ___Seizures/Epilepsy

___TB disease or exposure ___Vision problems

Is there any history among the parents or siblings of patient of…

___ADHD/ADD or behavior problems ___Allergies /"hay fever" ___Asthma ___Birth defects ___Bladder

___Kidney problem ___Cancer ___Chickenpox ___Autism ___Depression ___Anxiety ___Diabetes

___Eczema ___Hearing problems ___Heart disease or problem ___High blood pressure

___Learning disability or problem ___Meningitis ___Obesity ___Pneumonia ___Seizures/Epilepsy

___TB disease or exposure ___Vision problems ___Smoker indoors ___Smoker outdoors

Anything else you would like to share about your child's health:

_____

_____

_____

_____

Printed Name_____

Signature:_____

Relationship to patient _____ **Date**_____

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