

Name _____
D.O.B _____

Medical / Past Medical History Form

Is your child under a physician's care now? Yes or No If yes, who

Does your child take any medications, pills or drugs? Yes or No

Is your child allergic to any medications or have any allergies? Yes or No

What surgeries or procedures has your child had? Please include the year the procedure was done.

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes or No	Anemia	Yes or No
Anxiety	Yes or No	Juvenile Arthritis	Yes or No
Asthma	Yes or No	Blood Transfusion	Yes or No
Breathing Problems	Yes or No	Cancer	Yes or No
Chest Pains	Yes or No	Diabetes	Yes or No
Epilepsy or Seizures	Yes or No	Excessive Bleeding	Yes or No
Excessive Thirst	Yes or No	Fainting/Dizziness	Yes or No
Frequent Cough	Yes or No	Frequent Diarrhea	Yes or No
Frequent Headaches	Yes or No	Genital Herpes	Yes or No
Hay Fever	Yes or No	Heart Murmur	Yes or No
Heart Trouble/Disease	Yes or No	Hepatitis A	Yes or No
Hepatitis B	Yes or No	Hepatitis C	Yes or No
High Blood Pressure	Yes or No	High Cholesterol	Yes or No
Kidney Problems	Yes or No	Sickle Cell Disease	Yes or No

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Thyroidism Yes or No

ADD/ADHD Yes or No

Bedwetting Yes or No

Others:

Did you have any complications at birth or during pregnancy? If yes explain

Was your child born before 36 weeks? _____

Has he/she ever been hospitalized? _____ If yes, explain:

What medical conditions run in your Family? Also state who had the disease:

Is your child in school? _____ If so what grade? _____

How does your child perform in school? _____

Any difficulty concentrating? _____

How does your child sleep? Good/Fair/Poor

Please describe your child's diet to the best of your abilities. If he/she is formula fed, please list the types of formulas he/she has tried. If taking baby food tell what kind and what age it was started. Also include food allergies.

What's the reason for your child's visit?

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D.O.B _____

What are you looking for in a doctor?

How did you hear about us?
