Medical History Form

Child's Name: _____

Address: _____

Social Security #: _____ Nickname(s): _____

Age _____ DOB_____ ☐ Girl ☐ Boy ☐ Adopted

Race:

☐ African American

☐ American Indian/Alaskan Native

☐ Asian

☐ Caucasian/White

☐ Hawaiian/Pacific Islander

☐ Unknown

☐ Other: _____

☐ Declined

Ethnicity:

☐ Hispanic/Latino

☐ Non Hispanic/Latino

☐ Declined

Preferred Pharmacy/Location

_____

Parents/Legal Guardians Name(s) _____

_____

Parent/Guardian email: _____

Other Care Providers (physicians)

Name	Specialty	Location (City, State)

Birth History:

Birth Weight _____ Birth Length _____ Obstetrician _____

Birth Hospital/State _____

☐ Full Term (≥37wks) # of weeks:_____ ☐ Vaginal ☐ C/Section due to: _____

☐ Premature (<37wks) # of weeks:_____ ☐ Forceps ☐ Vacuum

Problems with Pregnancy:

- ☐ N/A
- ☐ Severe Vomiting
- ☐ Infection
- ☐ Migraines
- ☐ Obesity
- ☐ Thyroid Problems
- ☐ Anemia
- ☐ Seizure Disorder
- ☐ Diabetes
- ☐ Sexually Transmitted Disease (STD)
- ☐ HIV/AIDS
- ☐ Pre-eclampsia
- ☐ Hypertension
- ☐ Eating Disorder
- ☐ Depression
- ☐ Other

Problems with Labor/Delivery:

- ☐ N/A
- ☐ Preterm Labor
- ☐ Placenta Abruption
- ☐ Placenta Previa
- ☐ Prolonged Labor
- ☐ Breech
- ☐ Premature Rupture of Membranes
- ☐ Emergency C-Section
  if yes, why: _____
  _____

Did your child have any medical problems following birth? If so, please explain. _____

_____

During the pregnancy, did the mother smoke, drink alcohol, or take illegal drugs? If so, please explain. _

_____

Excluding vitamins and iron, list medications taken by the mother during pregnancy. _____

_____

Immunizations up to date? ☐ NO ☐ YES

Does your child receive dental care? ☐ NO ☐ YES

Dentist: _____ Date of Last Exam: _____

Does your child drink alcohol? ☐ NO ☐ YES, please explain: _____

Does your child use tobacco products? ☐ NO ☐ YES, please explain: _____

_____

Does your child use recreational drugs? ☐ NO ☐ YES, please explain: _____

_____

Is your child sexually active? ☐ NO ☐ YES, please explain: _____

_____

Has your child ever had any of the following conditions?

- ☐ Accidentally taken Medications or Poison
- ☐ ADD/ADHD
- ☐ Acid Reflux
- ☐ Acne
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Behavior Problems
- ☐ Bleeding/Clotting Disorder
- ☐ Broken Bones
- ☐ Bronchitis, chronic
- ☐ Cancer/Tumor
- ☐ Chicken Pox
- ☐ Chronic Cough
- ☐ Congenital Heart Disease
- ☐ Constipation
- ☐ Cuts Requiring Sutures
- ☐ Dental Problems
- ☐ Depression
- ☐ Developmental Delays
- ☐ Dyslexia
- ☐ Diabetes
- ☐ Emotional Abuse
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Frequent Nose Bleeds
- ☐ Frequent Stomach Ache
- ☐ Frequent Vomiting
- ☐ Hay Fever/Allergy
- ☐ Head Injuries
- ☐ Hearing Problems
- ☐ Heart Murmer
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Meningitis
- ☐ Physical Abuse
- ☐ Pneumonia
- ☐ Pyloric Stenosis
- ☐ Rash
- ☐ RSV
- ☐ Seizures
- ☐ Sexual Abuse
- ☐ Sinus Problems
- ☐ Sleep Issues
- ☐ Speech Delays
- ☐ Thyroid/Endocrine Disease
- ☐ Tuberculosis
- ☐ Urinary Issues
- ☐ Vision Issues
- ☐ Weight loss/gain

Allergies:

- ☐ Seasonal/Environmental: _____
- ☐ Medications: _____
- ☐ Food: _____
- ☐ Other: _____

List Current Medications: ☐ NONE

Medication	Dosage	Frequency	Reason

Hospitalizations: ☐ NONE

Date	Reason

Past Surgical History: ☐ NONE

Date	Surgery

Child Care: ☐ At Home ☐ Daycare

Education: ☐ Preschool ☐ Home School ☐ Grade School-grade:_____ ☐ College

Interests/Hobbies:

☐ Sports: _____

☐ Music: _____

☐ Dance: _____

☐ Art: _____

☐ Other: _____

Family Profile

Parents:

☐ Married ☐ Live together ☐ Divorced ☐ Separated ☐ Single-parent ☐ Remarried ☐ Other

Occupation: Father: _____ Mother: _____

Guns: ☐ NO ☐ YES

Smokers: ☐ NO ☐ YES

Heat: ☐ Gas ☐ Electric ☐ Wood ☐ Other, explain: _____

Pets: ☐ N/A ☐ Dog(s) ☐ Cat(s) ☐ Rabbit(s) ☐ Other: _____

Name of all persons living in child's home at present time

Name	Age	Relationship	Medical Concerns