CHILD PATIENT HISTORY

Name_____ Date of Birth_____ Age_____

Medical History: (circle all that apply)

Diabetes ADHD
Asthma Seizures
Allergies
Heart Disease (please describe)_____
Other _____

Surgeries: (please list **ALL** operations including the year)

_____ _____
_____ _____

Medication: (list any current medications)

_____ _____
_____ _____

Medication Allergies:

Medication What happened when you took this medication?

_____ _____
_____ _____

Social History:

List all household members_____
Are there smokers in the home? Yes / No
Are there any pets in the home? Yes / No

Birth History:

Pregnancy complications: None / Yes (please explain) _____
Type of Delivery: Vaginal birth / Cesarean section
Birth Complications: None / Yes (please explain) _____
Birth Weight: _____

Family History: (indicate which relative)

High Blood Pressure _____ Cancer (type) _____
Diabetes _____ Heart Attack _____
High Cholesterol _____ Stroke _____
Asthma _____ Seizure/Epilepsy _____
Emphysema/COPD _____ Other _____

Guardian Signature_____ Date_____