Medical Child Health History

Parent or guardian: Please fill out the following form to help us provide the best possible care to your child.
(Some questions may apply to a child older or younger than yours.)

PLEASE ANSWER THE QUESTIONS THAT APPLY TO YOUR CHILD.

Patient Information

Patient (Child) Name: _____ Date of Birth: _____ Age: _____
Mother's Name: _____ Father's Name: _____
If Guardian is not mother/father, give name & relationship to child: _____
Who lives with the child? _____ House or apartment? _____ Year Built: _____

Immunizations

Last date of immunizations: _____ Where: _____
Has the child had any reactions to immunizations in the past? YES NO
If yes, please specify: _____
Do you have a record of your child's shot history? YES NO If yes, please bring a copy to your child's next medical visit.

Past History

Has the child received regular medical care until now? YES NO If yes, who was the doctor?_____
Has the child received regular dental care until now? YES NO If yes, who was the dentist?_____
When was the child's last medical check-up? _____ Last dental check-up? _____
If less than 1 year old, do they sit in a rear-facing car seat? YES NO
If 1-4 years old, do they sit in a forward facing car seat? YES NO If 5-8 years old, do they sit in a booster sit? YES NO
Does the child have any personal habits that are a concern? (Thumb sucking, bed wetting, drug use, tobacco use)YES NO
If yes, please specify: _____
Does the child or your family have any religious beliefs that might affect medical care? YES NO
If yes, please specify: _____

Past Medical History – Has the child ever had the following: _____ Patient denies any past illness

	Condition	Dates		Condition	Dates
	Asthma			Depression	
	Allergies-Hay fever			Diabetes	
	Allergies-Other			Epilepsy/Seizures	
	Allergies-Other			Frequent Ear Infections	
	Birth Defects			Frequent Urinary Tract Infections	
	Bleeding Disorder			Kidney Problems	
	Cancer			Migraines	
	Other Diseases			Other Diseases	

Past Surgical History – Has the child ever had the following: _____ Patient denies any past surgeries
Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred

	Condition	Dates		Condition	Dates		Condition	Dates
	Appendix			Gallbladder			Hernia Repair	
	Ear Tubes			Tonsils/Adenoids			Other	

Medications – Please list all medications the child is currently taking _____ Patient denies any medications

Current Medications	Dosage (mg)	How often per day

Allergies – Please list all food, medication, and environmental allergies _____ Patient denies any allergies

Family History – Has any blood relative had any of the following: (Leave blank if uncertain)
Patient denies family history of: _____ Breast Cancer _____ Colon Cancer _____GYN Cancer

Condition	Relationship to you
Cancer Type:	
Diabetes Type:	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Problem	

Menstrual History

Age of 1st period: _____ # of days between period: _____ Total days on period: _____ Date of last period: _____
Flow: _____ Light _____ Medium _____ Heavy Does child tend to clot: YES NO
Birth Control: YES NO Name of birth control: _____

Pregnancy History

Total number of pregnancies: _____ Full term pregnancies: _____ Premature Births: _____ Multiple births: _____
Terminated Pregnancies: _____ Miscarriages: _____ Ectopic pregnancies: _____ Living: _____

Social History

Tobacco: ___ Never ___Minimal ___YES (____ packs/day x ____ years) ____ QUIT _____ Years ago (____ packs/day x ____ yrs)
Alcohol: ___ Never ___Minimal ___ Less than 10 a week, ____ More than 10 a week, ____ QUIT _____ Years ago
Recreational Drugs: ___ Never ___Minimal ___ YES (____ packs/day x ____ years) ____ QUIT ____ Years ago (____ packs/day x ____ yrs)

Printed name of person completing this form: _____Relationship to patient: _____

Signature: _____ Date: _____