Initial Medical History

Name of Patient _____ DOB ____/__/____

Form Completed by _____ Relation to Patient _____

Family

Are Father and Mother Married Seperated/Divorced Other

If seperated / divorced, what is the patient's custody status? _____

If one or both parents are not living in the home, how often does child see that parent?

Are there siblings living away from home? Yes / No

If yes, give name, age and where they live: _____

Current Medical History

Is your child having medical problems? Yes / No _____

Do you consider your child in good health? Yes / No _____

Current Medications: _____

Drug Allergies? Yes / No _____

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:		Explain
1. a serious medical problem?	Y / N	
2. been hospitalized or had surgery?	Y / N	
3. had a serious injury or accident?	Y / N	
4. chickepox? When?_____	Y / N	
5. allergies, asthma, bronchitis, respitory infections?	Y / N	
6. repeated ear infections, tubes, difficulty with hearing?	Y / N	
7. problems with eyes or vision?	Y / N	
8. heart problems or a hear murmur?	Y / N	
9. anemia, bleeding problems or blood transfusion?	Y / N	
10. abdominal pain, constipation requiring doctor visits?	Y / N	
11. recurrent vomiting, recurrent diarrhea, blood in stools?	Y / N	
12. bladder or kidney infections, bed-wetting after 5 yrs.?	Y / N	
13. recurrent skin problems (acne, eczema, etc.)?	Y / N	
14. headaches, convulsions, other neurologic problems?	Y / N	
15. diabetes, thyroid or other endocrine problems?	Y / N	
16. if female, has she started her menstrual periods?	Y / N	

if yes, LMP_____/_____/_____

Any problems?_____