Child Patient History Form

Please help us get to know you better by answering the questions on both the front and back of this form.

Name	Date of Birth
Where has your child gone for medical care before now?	
What is the date of your child's last check-up?	
What is the date of your child's last dental check-up?	

ALLERGIES

Allergic to any medications?	No	Yes	List:
Adverse reaction to medications?	No	Yes	List:
Allergic Reactions to foods or bee stings?	No	Yes	List:

MEDICATIONS

List all medications you currently take including prescription medications, over-the-counter medications and herbal remedies

1	3	5
2	4	6

PATIENT'S MEDICAL HISTORY

Has your child had recent immunizations?	YES	NO
If yes, please list		
Any hospitalizations other than birth?	YES	NO
If yes, please list		

ILLNESSES AND MEDICAL PROBLEMS

Has your child had frequent ear infections?	YES	NO
Has your child had any eye or vision issues?	YES	NO
Has your child had any issues with teeth?	YES	NO
Does your child have frequent cold or sore throat?	YES	NO
Is there asthma, or pneumonia?	YES	NO
Does your child have heart murmur or any heart problem?	YES	NO
Any problems with urination?	YES	NO
Any problems with diarrhea or constipation?	YES	NO
Any eczema, hives, or other skin issues?	YES	NO
Does your child suck their thumb?	YES	NO
Does your child have a bed wetting problem?	YES	NO
Did your child have trouble toilet training?	YES	NO
Does your child have hyperactivity problems?	YES	NO
Does your child have nightmares?	YES	NO
Does your child have speech problems?	YES	NO

PREGNANCY AND BIRTH

Mother's age at birth of child		
Did mother have any illnesses during pregnancy?	YES	NO
Did mother use any medications other than vitamins?	YES	NO
Was baby born on time?	YES	NO
What was the birth weight?	YES	NO
Did the baby have any trouble starting to breath?	YES	NO

Did the baby have any trouble in the hospital?	YES	NO

FAMILY HISTORY

Check if there is a family history of the medical problems noted below

(mother, father, siblings, grandparents)

Problem	**Relationship To Patient**		**Problem**	**Relationship To Patient**
Cancer (specify)			Epilepsy	
Diabetes			Glaucoma	
Heart Disease			Stroke	
High blood pressure			Rheumatoid	

GENERAL HEALTH, AGE AND SEX OF SIBLINGS

Name	Health	Age	Sex
Have any of your children passed away?		YES	NO

FEEDING AND NUTRTION

Was there severe colic or any unusual feeding problems during the first three months of life?	YES	NO
Is/was your child **breast** or **bottle** fed or **both**?	YES	NO
If still on formula, which one do you use?	YES	NO
Does your child take vitamins?	YES	NO

DEVELOPMENT/BEHAVIOR

At what age did your child sit alone?	YES	NO
At what age did your child walk alone?	YES	NO
Did your child say any words by the time he/she was 1 1/2 years old?	YES	NO
Does your child have trouble sleeping?	YES	NO
Has your child had any trouble in school?	YES	NO
Does your child get along with other children?	YES	NO

SAFETY/ENVIRONMENTAL

Do you know the hottest temperature of the water in your pipes?	YES	NO
Is there a working smoke alarm on each floor where you live?	YES	NO
Does your child always use a seat belt/ car seat in the car?	YES	NO
Are there any smokers in the household?	YES	NO
Are there any problems with the condition of you home such as peeling paint, insects, rats or mice?	YES	NO
Does your child wear a helmet when bike riding?	YES	NO
Do you have any firearms in the house?	YES	NO
Have any of the child's caregivers been trained in CPR?	YES	NO
Do you have the number to POISON CONTROL?	YES	NO

PARENT/GUARDIAN SIGNATURE: Date:

FOR OFFICE USE ONLY

Reviewed by:		Date