

**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian(s): \_\_\_\_\_ Child lives with (names): \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us?  Referred by physician (name; address; phone no.) \_\_\_\_\_

- Referred by friend    Internet Search    Community Lecture  
 Advertisement:    Radio Ad    Billboard    Magazine Ad    TV Program

Other \_\_\_\_\_

What is the reason for today's visit: \_\_\_\_\_

When did the problem first begin? \_\_\_\_\_

Problems during pregnancy/delivery (be specific) \_\_\_\_\_

Birthweight: \_\_\_\_\_ Age child rolled over: \_\_\_\_\_ Sat: \_\_\_\_\_ Walked: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List past surgeries, fractures, illnesses or hospital stays: (if additional room is needed, add to back of page)

Reaction to any anesthesia? \_\_\_\_\_

Past medical problems: \_\_\_\_\_

Does the patient have or has ever had:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Seizures (convulsions) | <input type="checkbox"/> Bruise easily       | <input type="checkbox"/> Kidney disease  | <input type="checkbox"/> Urinary problems             |
| <input type="checkbox"/> Frequent headaches     | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Liver disease   | <input type="checkbox"/> Fever                        |
| <input type="checkbox"/> Problems with eyesight | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Lung disease    | <input type="checkbox"/> Growth problems              |
| <input type="checkbox"/> Problems hearing       | <input type="checkbox"/> Recent cold/illness | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Unexplained rashes or fevers |

Other (specify) \_\_\_\_\_

List any allergies: (medicine/food) \_\_\_\_\_

Medications: \_\_\_\_\_

Are there any conditions/illnesses that occur in your family (eg. Arthritis, heart disease, diabetes)? \_\_\_\_\_

Smoking: \_\_\_\_\_ Packs per day? \_\_\_\_\_ Drug or Alcohol use: \_\_\_\_\_ Emotional Problems: \_\_\_\_\_

FEMALES ONLY: Menstruation – age began: \_\_\_\_\_ Regular or irregular? \_\_\_\_\_ How many periods per year? \_\_\_\_\_

Patient/Legal Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_