



Complete Patient Medical History

Patient Name: _____

Date of Birth: _____ Sex: _____ Age: _____

Medication Allergies: _____

Please list all individuals living in household and their relationship to the patient: _____

Please list all medications patient is currently taking including Vitamins, fluoride, herbal supplements and over the counter medications: _____

Current Diet: _____ If infant; Breast or Formula: _____ Brand: _____

Appetite: _____ Feeding problems: _____

List all allergies to foods or environment: _____

Please list previous illnesses, surgeries and past hospitalizations with dates:

If menstrual; date of first period: _____ Date of last period: _____

Dates of past immunizations

DTaP				
HIB				
Polio				
MMR				
Hepatitis B				
Varicella				
Prevnar				
Other				

Which parents work outside the home? _____

What kind of sitter arrangements does the child have? _____

If divorced or unmarried is the other parent involved with the child? _____

Has child ever eaten anything unusual such as paint chips, dirt, plants, etc.? _____

If yes, please explain: _____

Was child adopted? _____ If yes, at what age? _____

Mother's health during pregnancy of this child: Good _____ Complications _____

If complications, please describe: _____

Which pregnancy number was this for Mom? _____ Normal delivery or c- section? _____

What was child's birth weight? _____ Birth length? _____

Where was child born? Name of Hospital: _____

Was the child diagnosed with any problems at birth? _____

Was child hospitalized after mother's discharge? _____

Of the child's 4 grandparents, how many are living and well? _____

Do any blood relatives of child have any of the following conditions:

Disease	No	Yes	Whom- specify relationship to child plus Maternal or Paternal
Diabetes			
Kidney Disease			
Blood Disorders			
Arthritis			
Asthma			
Eczema			
Thyroid Disorder			
High Blood Pressure			
Heart Disease			
Cancer (specify)			
Tuberculosis			
Seizure Disorder			
Mental Retardation			
Seasonal Allergies			
Unusual Defects or Syndromes			
Other conditions not listed			

Compared to other children was this child's development: Slower, Faster, or Average? (please circle)

If attending school, type of grades achieved: _____

Are there any problems with child getting along at home or with playmates? _____

If yes, please explain _____

Has child even been under professional mental health care or counseling? _____ If yes, by whom?

Please list all pets in the home or that child has contact with: _____

Water source: City _____ Well _____ Bottled _____

Is home air-conditioned? Yes ___ No ___

Heat source: Gas _____ Electric _____ Other _____

Smokers present in home? Yes _____ No _____ Whom? _____

Has child ever had any of the following conditions? Please check and explain in lines below

Allergies	Nosebleeds	Bed wetting	Bleeding tendency
Asthma	Measles	Eczema	Rheumatic Fever
Anemia	Pneumonia	Frequent Diarrhea	Fractures (specify)
Chicken Pox	Slow Growth	Frequent Illness	Mononucleosis
Backaches	Ear Infections	Unusual Weight Loss	Attention Deficit
Sore Throats	Vision Problems	Unexplained Fevers	Worms
Headaches	Hearing Problems	Urine/ Kidney Problems	Eating Disorder
Seizures	Speech Problems	Menstrual difficulties	Depression
Sore or Swollen Joints	Protein, Blood or Sugar in Urine	Problems with walking or posture	Loss of Consciousness or Been knocked out

Parent, Patient or Guardian's Signature:

Date:

X _____

Thank you for your cooperation