Patient Health History Form

To provide optimal care for your child, it is important for us to learn as much about him/her as possible. Please fill out this form as completely as you can. If you are unsure about a question, we are happy to discuss the issue with you. Your child's information will be considered confidential.

Please note, most of these questions can be answered with a checkmark

Medical History:

____My child has no diseases or conditions

My child has the following diseases or conditions:

____ADHD

____Allergies

____Anemia

____Anxiety Disorder

____Asthma

____Autism Spectrum Disorder (ASD)

____Bedwetting

____Bladder or Kidney Disease

____Blood Diseases

____Cancer

____Chicken Pox

____Chronic Ear Infections

____Congenital Anomalies

____Constipation

____Depression

____Developmental or Behavioral Disorders

____Diabetes

____Difficulty Swallowing

____Ear or Hearing Problems

____Head Injury/Concussion

____Headaches

____Heart Problems/Murmur

____Hospital Admission Other Than Birth

____Mental Illness

____Muscle, Joint, or Bone Problems

____Seizures/Epilepsy

____Skin Problems

____Thyroid Problems

____Vision or Eye Problems

____Reviewed With No Changes

Social History:

Animal Exposure? ___yes ___no

Bike Helmets? ___yes ___no

Blind or Serious Difficulty Seeing? ___yes ___no

Bully/Bullying? ___yes ___no

Changes in Family/Social Situation? ___yes ____no

Childcare? ___none ____relative ____private sitter ____daycare/preschool

Deaf or Serious Difficulty Hearing? ___yes ___no

Diet? ___regular ____vegetarian ____vegan ____gluten-free ____specific

____carbohydrate ____cardiac ____diabetic

Exercise Level? ____none ____occasional ____moderate ____heavy

Fluoride Status of Home Water? ____fluoridated ____non-fluoridated ____unknown (If your home receives city water, then it IS fluoridated)

General Stress Level? ____low ____medium ____high

Guns Kept in Secure Location and With Gun Lock? ____yes ____no

Exposure to Illicit Drugs (Past or Present)? ____

Parents' Marital Status? ____married ____unmarried ____separated ____divorced

____widowed

Number of People in Household? ______: This includes ____siblings _____grandparents ____extended family ____friends

Passive Smoke Exposure? ___yes ____no

Pool Exposure? ____yes ____no

School Name? ____

Seat Belt/Car Seat Used Routinely? ____yes ____no

Siblings? ____yes ____no

Smoke Alarm in Home? ____yes ____no

Smoke/CO Detectors in Home? ____yes ____no

Sporting Activities? ____

Year in School? ____

____Reviewed With No Changes

Family History: If You Check a Disease/Condition, Please Indicate How the Affected Individual is Related to Your Child (e.g., Mother, Father, Sibling, Grandparent, etc.)

____No Diseases or Conditions

____Allergies

____Anemia

____Anxiety Disorder

____Asthma

____Blood Coagulation Disorder

____Depressive Disorder

____Developmental Disorder

____Diabetes Mellitus

____Disease of Liver

____Disorder of Thyroid Gland

____Heart Disease

____Hypercholesterolemia

____Hypertensive Disorder

____Immunodeficiency Disorder

____Kidney Disease

____Malignant Neoplastic Disease

____Mental Disorder

____Migraine

____Seizure

____Substance Abuse

_____Tuberculosis

_____Reviewed With No Changes

Surgical History:

____No Surgeries

____Adenoidectomy

____Appendectomy

____Cardiac Surgery

____ER/Urgent Care Visit

____Ear Tube

____Medical Hospitalization

____Other

____Tonsillectomy

____Reviewed With No Changes

Medications:

____No Current Medications

Add a Medication:

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:______________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:____________________________ DOSAGE:___________________ TIME of DOSES:_______
NAME:____________________________ DOSAGE:___________________ TIME of DOSES:_______

NAME:____________________________ DOSAGE:___________________ TIME of DOSES:_______

Allergies:

____No Allergies

Add an Allergy:

Cause/Name of Allergy:____

____

____

Immunizations:

____No Vaccinations (If So, Please Explain:____)

____To the Best of My Knowledge, My Child is Up To Date With Their Vaccines

____My Child May Need the Following Immunization(s):

___Influenza

___DTaP

___Hep A

___Hep B

___Hib

___Polio

___MMR

___Varicella (Chicken Pox)

___TdaP

___Meningococcal

___Pneumococcal

___Rotavirus

___Tetanus

___Gardasil

____Reviewed With No Changes