Patient Information and Medical History (Updated 08/2022)

Child's Full Name _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____

Zip Code _____ **Phone Number** _____ **Alternate Phone Number** _____

Parent (1) Name _____
Date of Birth _____
Parent (1) SSN _____
Parent (1) Occupation _____
Does Parent (1) live with Child? [ ] Yes [ ] No

Parent (2) Name _____
Date of Birth _____
Parent (2) SSN _____
Parent (2) Occupation _____
Does Parent (2) live with Child? [ ] Yes [ ] No

Siblings Names/Birthdates:

_____

_____

Legal Guardian Name _____

Emergency Contact (Name and Phone number) _____

Medical History	Yes	No	Explain (include dates if known)
Does your child have any chronic conditions or diseases?			
Hospitalization?			
Surgeries?			
Emergency Room Visits?			
Food Allergies?			
Medication Allergies?			
Immunization reactions?			

Check if your child has *ever* had any of the following:

[ ] Chickenpox
[ ] Frequent ear infections (>5/yr)
[ ] Urinary tract infections
[ ] Frequent headaches
[ ] Heart murmur
[ ] Seizures/Epilepsy
[ ] Anemia/low blood count
[ ] Loud snoring
[ ] Pneumonia
[ ] Depression/emotional problems
[ ] RSV/Bronchiolitis
[ ] Eating disorder/Anorexia
[ ] Stomach problems/reflux
[ ] Poor school performance
[ ] other explain below

Explain _____

_____

_____

Family History (This should include grandparents, aunts, uncles, etc. Please indicate which relative by illness)

[ ] ADD / ADHD _____
[ ] Alcoholism/Drug Abuse _____
[ ] Allergies-nasal;Environmental,Food_____
[ ] Arthritis_____
[ ] Asthma/RAD_____
[ ] Autoimmune Disorder-Lupus,Psoriasis_____
[ ] Blood Disorder-Hemophilia,Sickle Cell,Bleeding Problems _____
[ ] Bed Wetting_____
[ ] Cancer_____
[ ] Complications from Anesthesia_____
[ ] Congenital Birth Defects_____
[ ] Congenital Heart Disease-VSD,Tetrology,Single Ventricle _____
[ ] Developmental Delay/Disorder-Autism,Speech Delay _____
[ ] Diabetes-Onset under 25yrs_____
[ ] Down's Syndrome_____
[ ] Ear Problems-Cholesteotoma,Frequent Ear Infections _____
[ ] Eczema_____
[ ] Epilepsy/Seizures/Convulsions_____
[ ] Eye Problems-Crossed eye,Glaucoma,Cataracts _____
[ ] Family Violence/Domestic Abuse_____
[ ] Gastrointestinal Problems-Ulcers,IBS,Reflux,Inflammatory Bowel_____
[ ] Hearing Loss from birth-Congenital deafness_____ _____
[ ] Heart Disease-Under 50 yrs_____
[ ] High Blood Pressure_____
[ ] High Cholesterol/Triglycerides_____
[ ] Immune Disorder _____
[ ] Infant -SIDS_____
[ ] Kidney Disease/problems_____
[ ] Learning Disabilities_____
[ ] Liver Disease-Jaundice_____
[ ] Mental Illness-Depression,Anxiety_____
[ ] Mental Retardation_____
[ ] Migraines_____
[ ] Obesity_____
[ ] Schizophrenia_____
[ ] Scoliosis_____
[ ] Sexually Transmitted Disease-AIDS,Syphilis_____
[ ] Stroke-Under 50yrs_____
[ ] Sudden Athletic Death-Arrhythmia_____
[ ] Tuberculosis(TB)_____
[ ] Thyroid/Hormone Problems_____
[ ] Rare-Disease-Cystic Fibrosis,Multiple Sclerosis,Muscular Dystrophy,Neurofibromatosis_____
[ ] Explanations/Other Family Health Issues_____
_____
_____
_____
_____
_____
_____
_____

Please list any health concerns you have

_____
_____
_____

Please list any medication your child is currently taking

_____
_____
_____

Do you have any concerns about your child's development or behavior? [ ] Yes [ ] No

The following individuals are able to authorize medical treatment form my child(ren) in my absence:

Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____

Parent or Guardian Signature _____ **Today's Date** _____