

CHILD/MINOR PATIENT MEDICAL HISTORY

Appointment date: _____ Time: _____ Dr. _____

Name: _____ DOB: _____

Pharmacy/Location: _____ Email Address: _____

Insurance Name: _____ Insurance ID#: _____

Father (Full Name): _____ Mother (Full Name): _____

Birthdate: _____ SS#: _____ Birthdate: _____ SS#: _____

Address: _____ Address: _____

Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____
(Cell) _____ (Cell) _____

Employer _____ Marital Status _____ Employer _____ Marital Status _____

Child/Minor Patient Medical History

What is the main reason for today's visit? _____

How long has this been a problem? _____ Hours _____ Days _____ Weeks _____ Months _____ Years

Please list any other complaints you want to discuss today. _____

Who is the child's pediatrician or family doctor? _____

Has your child ever taken antibiotics, over-the-counter meds or other medications for this problem? Yes No

If so, please list. _____

Have X-rays, CT scans, MRI scans or allergy tests been obtained for this problem? Yes No

If so, when and where were they taken? _____

Past Medical History

Was your child born full term? Yes No

Any problems with the child's growth and development? Yes No

If yes, please explain: _____

Past Surgical History

Please write down any previous surgeries and the approximate dates; if more room is needed, please attach a separate sheet. _____

Does your child have any **medical problems** that require regular visits or medications? (Please check)

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Muscle/Bone problems |
| <input type="checkbox"/> Asthma/Reactive airway disease | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Reflux/Heartburn |
| <input type="checkbox"/> Bleeding problems/Bruising | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver/Kidney disease | <input type="checkbox"/> Skin disease/Rash |
| <input type="checkbox"/> Leukemia/Lymphoma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid gland problems |
| <input type="checkbox"/> Other: _____ | | |

List medications and doses, including aspirin, herbal medicines, over-the-counter medicines and vitamins, that you take on a regular basis. _____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO:

Medication: _____ Reaction: _____

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Medication: _____ Reaction: _____

Family History Please list any relatives that have or have had any of the following (maternal or paternal).

Hearing loss: _____ How related: _____ Cancer: _____ How related: _____

Diabetes: _____ How related: _____ Asthma: _____ How related: _____

Heart trouble: _____ How related: _____ Allergies: _____ How related: _____

Bleeding or clotting problems: _____ How related: _____

Social History

Who lives at home with the patient? Brothers _____ Sisters _____

Does anyone in the home smoke? Yes No

Are there pets in the home? Yes No If yes, what animals? _____

Is the child in day care? Yes No School/Elem _____ Middle _____ High School _____

Review of Systems Please check any medical problems the child is currently having.

Body as a Whole

- Fatigue
- Fevers
- Weight loss
- Weight gain
- Headache
- Facial pain
- Flat spot

Ears

- Drainage
- Decreased hearing
- Fluid
- Recurrent infection
- Pain
- Speech delay
- Imbalance/Not walking
- Dizziness

Nose

- Drainage
- Stuffiness
- Bad smell
- Polyps
- Foreign object
- Bleeding
- Frequent colds

Neck

- Large glands
- Pain
- Cyst or lump
- Thyroid problems

Throat

- Drainage
- Pain
- Tonsillitis
- Bad breath
- Snoring
- Large tonsils
- Noisy breathing
- Throat clearing
- Hoarseness
- Cough

Allergies

- Sneezing
- Pets in home
- Spring allergies
- Summer
- Fall
- Winter
- Foods

Eyes

- Mattering
- Redness
- Dark circles

Lungs

- Asthma
- Wheezing
- Bronchitis

Heart

- Murmur
- Surgery
- Extra beats

Stomach/GI

- Diarrhea
- Constipation
- Cramps
- Heartburn
- Reflux

Urinary Tract

- Frequency
- Burning
- Stones

Muscle/Bones

- Joint pain
- Joint swelling
- Weakness

Skin

- Eczema
- Itching
- Hives
- Rash
- Moles

Neurological

- Seizures
- Numbness
- Paralysis
- Tremor

Psych

- Depression
- Anxiety
- Attention deficit