

Today's Date _____

Patient's Full Name: _____

Patient's Date of Birth: _____

1. Has your child every had an allergy to any medication? _____	Which one? _____
2. Has your child ever had chickenpox (varicella)? _____	
3. Has your child ever been hospitalized? _____	
4. Has your child ever needed emergency treatment? _____	For what? _____
5. Has your child ever had surgery? _____	For what? _____
6. Does your child have any non-drug allergies/Food allergies? _____	
7. Does your child have any ongoing medical problems? _____	
8. Is your child in good health? _____	
9. Does your child have a special diet or vegetarian? _____	
10. Has your child ever lived/spend time in an older building that has not been renovated since 1960?	
11. Is there a gun kept in the place where your child lives? _____	Locked up/ammo separate? _____

Patient Health History

Has your child ever had or now have...

General History

Does child:

	Yes	No		Yes	No
Eye/Vision Problem			Have immunizations up to date		
Ear/Hearing Problem			Take Medicine regularly		
Dental Problems			See Dentist regularly		
Speech Problems			Behavior Problems		
Fainting Spells			<i>Has your child ever had or now have...</i>		
Urine/Kidney Infections				Yes	No
Wheezing or Asthma			Frequent Headaches		
Heart Condition/Heart Murmur			Discipline Problems		
Anemia/Blood Problems			Trouble getting along with others		
Bedwetting			Restlessness/Fidgety		
Seizures/Convulsions			Nervousness or Fearful		
Recurrent Skin Rash/Eczema			Persistently Sad or Depressed		
Stomach or Bowel Problems			Drug/Tobacco/Alcohol Use		
Recurrent Sore Throat			Sexual Activity or Molestation		
Joint Pain or Swelling			Trouble in School		
Fractures/Bone problems			Aggressive Behavior		
Rheumatic Fever			Eating Problems/Eating too much/little		
Tuberculosis			Any other information you would like us to know about your child?		
Positive TB test					
Hepatitis					