PLEASE COMPLETE BOTH SIDES

HEALTH HISTORY

PATIENT NAME_____ **DOB**_____ENT **AGE**_____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR CHILDS MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Today's date_____ When was your child's last physical exam?_____

1. PAST MEDICAL HISTORY – Has your child ever had the following: **__Patient denies any PMH**

	Dates		Dates		Dates
__Gastro disorder	_____	__ ADHD	_____		
__ Heart disease	_____	__Renal Failure	_____		
__ Anemia	_____	__ Hematuria	_____	__ Skin Disorder	_____
__ Anxiety Disorder	_____	__ Hyper Cholesterol	_____	__ Systemic Lupus	_____
__ Arthritis	_____	__ Hypertension	_____		
__ Calculus of Kidney	_____	__ Hyperthyroidism	_____	__Traumatic Injury	_____
__ Cholecystitis	_____	__ Hypothyroidism	_____	__ Urinary Incontinence	_____
__ Coagulation Defeat	_____	__Joint Disorder	_____	__ Urinary Tract Inf	_____
__ Convulsions	_____	__Kidney Disorder	_____	__ any other disease	_____
__ Eczema	_____	__Liver Disorder	_____		
__ Depression	_____	__ Cancer	_____		
__ Diabetes	_____				
__ Esophageal	_____	__ Osteoarthritis	_____		

2. PAST SURGICAL HISTORY – Has your child ever had the following: **__ Patient denies any surgeries**

Please list all serious illnesses, operations & other hospitalizations your child has experienced and indicate year these occurred

☐ Appendectomy _____	☐ Tonsillectomy _____	☐ VP Shunt _____
☐ Adenoids _____	☐ Knee/Foot _____	☐ Fracture Repair _____
☐ Dental Surgery _____	☐ Hernia Repair _____	☐ PE Tube Placement _____
☐ Eye Surgery _____	☐ Splenectomy _____	☐ Renal Surgery _____

3. MEDICATIONS: Please list all **medicines** your child is currently taking ☐ please continue on back of sheet

__ Patient denies taking any Medications

CURRENT MEDICATIONS:	DOSAGE (mg)	how often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **ALLERGIES** (food, drugs, and environment) **__ Patient denies any Allergies** **What was the reaction**

_____ _____

_____ _____

_____ _____

4. FAMILY HISTORY: Has any blood relative had any of the following: (Check box, leave blank if uncertain)

Denies family history of **__Breast Cancer** **__ Colon Cancer** **__ GYN Cancer**

	Relationship/Paternal or Maternal	
□ Bleeding Disorder	_____	□ Type _____
□ Cancer	_____	□ Type _____
□ Diabetes	_____	□ Type _____
□ Heart Disease	_____	□ Stroke _____
□ High Blood Pressure	_____	□ Genetic Problem _____
□□ Kidney Problem	_____	□□Mental Health _____
□ Asthma	_____	

5. PATIENT SOCIAL HISTORY:

Smoking _____ If so how often_____

Alcohol (type & amount per week)_____ Educations: _____

Street drugs (type & amount per day)_____ Marital Status:_____

History of Abuse: □ Physical □ sexual

6. REVIEW OF SYSTEMS:

DOES YOUR CHILD CURRENTLY HAVE:
(Please circle anything for which you have a history of)

Constitutional:	fever	fatigue	night sweats	
Eyes:	eye pain	blurred vision	double vision	
HENT:	sinus pain	headaches	lightheadedness	Tinnitus
Cardiovascular:	chest pain	irregular heartbeats	rapid heart rate	
Respiratory:	shortness of breath	coughing up blood	Productive cough	Asthma/wheezing
Gastrointestinal:	Loss of Appetite	nausea	vomiting,	
Genitourinary:	urgency	hemature	dysuria	
Integument:	rash	itching	new skin lesions	pigmentation change
Neurological:	seizure	alter mental status	speech difficulty	
Musculoskeletal:	joint pain	muscle pain	joint swelling	
Endocrine:	excessive urinating	excessive drinking	loss weight	
Psychiatric:	anxiety	depression	difficulty sleeping	
Heme-Lymph:	easy bleeding	easy bruising		

_____ _____

Signature of Patient or parent if minor **Date**