PATIENT MEDICAL HISTORY FORM

Date:	Name:	DOB:

BIRTH HISTORY

Birth Weight_____
Mom's age _____
Premature? Y N
Vaginal or Ceasarean ?

Birthplace _____
During pregnancy did mom:
smoke? Y N drink? Y N
use other drugs or medications? Y N

Any issues after birth?
(jaundice, feeding, respiratory)
_____
_____

MEDICAL HISTORY

	Y	N	Explain
Has your child ever been hosptitalized?			
Has your child ever had surgery?			
Any serious accidents or injuries?			
Any chronic medical conditions?			
Daily medications?			
Reactions to immunizations?			
Does your child have now, or has he/she ever had…			
Asthma or recurrent wheezing			
Allergic rhinitis or eczema			
Recurrent ear infections or hearing concerns			
Problems with eyes or vision			
Frequent headaches or migraines			
Genetic or Metabolic disorders			
Gastrointestinal issues			
Bladder or kidney infections			
Heart problems, murmurs, high blood pressure			
Anemia or bleeding problems			
Endocrine issues (thyroid, growth, diabetes)			
History of cancer			
Mental health issues (ADHD, anxiety/ depression)			
Any other medical conditions?			
Does your child see any specialists?			
Has your child received OT/PT/ Speech therapy?			

Any other medical conditions not listed above?_____

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