

Medical History Form

New Patient

Patient's Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Your relationship to the patient: Parent Legal Guardian Other _____

What medical problems are we seeing your child for today? _____

Have you previously seen either of our doctors at a different office? **Yes / No**

Does anyone in the household smoke? **Yes / No**

Does your child attend daycare? **Yes / No**

Does your child attend school? **Yes / No** If yes, what grade? _____

Are your child's immunizations up to date? **Yes / No**

Medical Illnesses

Does your child **have** or **ever had** any of the following?

ADHD or ADD	Yes / No	Heart Disease	Yes / No
Asthma	Yes / No	Heart Murmur	Yes / No
Bleeding Problems	Yes / No	Kidney Disease	Yes / No
Cancer	Yes / No	Liver Disease	Yes / No
Depression/Anxiety	Yes / No	Neurological Disorder	Yes / No
Diabetes	Yes / No	Seizure Disorder	Yes / No
Gastroesophageal Reflux (GERD)	Yes / No	Syndrome	Yes / No
Gastrointestinal Disorders	Yes / No	Other	Yes / No
<i>Please Describe Other and Yes Answers from above:</i> _____			

Birth History

Full Term Premature *How many weeks premature?* _____

Did your child ever stay in the NICU? **Yes / No** If yes, how long? _____

Has your child ever required a breathing tube? **Yes / No** If yes, how long? _____

History of Surgeries

Please list **all** surgical procedures your child has had:

<i>Procedure</i>	<i>Date</i>	<i>Surgeon/Location</i>

Medications

Does your child have ANY medication allergies? **Yes / No**

If yes, which medication(s) and what type of reaction? _____

Is your child currently taking any medications? **Yes / No**

If yes, what medications (Please include over the counter medications: vitamins, Tylenol, etc...)

Does anyone in your family have a history of any of the following?

Anesthesia Difficulties (more than nausea and vomiting) Yes / No	Excessive Bleeding with Childbirth Yes / No
Bleeding Disorder Yes / No	Excessive Bleeding with Surgery Yes / No
Early Hearing Loss (< 40) Yes / No	Thyroid Disorder Yes / No
Easy Bruising Yes / No	Kidney Disease Yes / No
If you answered yes, what is their relationship to your child and what is the history?	

Has your child recently had?

Ear infections Tonsillitis/Strep Throat Sinus Infections Nosebleeds

Total number of episodes _____ in _____ (amount of time).

If applicable, please check the antibiotics given to treat your child:

Amoxicillin Augmentin Bactrim Biaxin Celcor Cefdin Cefzil Clindamycin
 Erythromycin Omnicef Pediazole Septra Suprax Vantin Zithromax
 Rocephin Shots Other _____

Does your child have any of these symptoms today?

Ear, Nose, & Throat	Yes	No		Yes	No		Yes	No
Pulling at ears			Ear drainage			Ear pain		
Ear swelling			Itchy ear			Hearing loss		
Dizziness			Imbalance			Nasal obstruction		
Nasal congestion			Runny nose			Itchy nose		
Postnasal drip			Nose bleeds			Enlarged tonsils		
Snoring			Mouth breathing			Sore throat		
Bad breath			Throat clearing			Difficulty swallowing		
Hoarseness			Change in voice			Course cry		
Neck pain			Neck swelling			Thyroid mass		
Other Systems								
Wheezing			Cough			Breathing retractions		
Stridor			Noisy breathing			Frequent spitting up		
Seizures			ADHD			ADD		
Easy bleeding			Easy bruising			Fatigue		

Name of individual completing form (print): _____

Signature: _____ Date: _____