Personal Medical History Form

(Please Print)

Name: ____

Date of Birth: ________________ Age: __________________

Address: ____

____

Parent /Guardian's Name: ____ DOB: _______________

Parent /Guardian's Name: ____ DOB: _______________

Social History

Are there siblings? If so, please list their names, ages, and where they live ______________________________

____

What is the child's living situation if not with both biological parents? ☐ Lives with adoptive parents
☐Joint custody ☐Single custody ☐Lives with foster family
If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

____

Medical History

Does your child have, or has your child ever had,

- ☐ Chickenpox -- When?
- ☐ Frequent ear infections
- ☐ Problems with ears or hearing
- ☐ Nasal allergies
- ☐ Problems with eyes or vision
- ☐ Asthma, bronchitis, bronchiolitis, or pneumonia
- ☐ Any heart problem or heart murmur
- ☐ Anemia or bleeding problem
- ☐ Blood transfusion
- ☐ HIV
- ☐ Organ transplant
- ☐ Malignancy/bone marrow transplant
- ☐ Chemotherapy
- ☐ Frequent abdominal pain
- ☐ Constipation requiring doctor visits
- ☐ Recurrent urinary tract infections
- ☐ Congenital cataracts/retinoblastoma
- ☐ Metabolic/Genetic disorders
- ☐ Cancer
- ☐ Kidney disease or urologic malformations
- ☐ Bed-wetting (after 5 years old)
- ☐ Soiling underwear (encopresis)
- ☐ Sleep problems; snoring
- ☐ Chronic or recurrent skin problems (acne, eczema)
- ☐ Frequent headaches
- ☐ Convulsions or other neurologic problems
- ☐ Obesity
- ☐ Diabetes
- ☐ Thyroid or other endocrine problems
- ☐ High blood pressure
- ☐ History injuries/fractures/concussions
- ☐ Use of alcohol or drugs
- ☐ Tobacco use
- ☐ ADHD/anxiety/mood problems/depression
- ☐ Developmental delay
- ☐ Dental decay
- ☐ History of family violence
- ☐ Sexually transmitted infections
- ☐ Pregnancy
- ☐ (For girls) Problems with her periods
- ☐ Has had first period -- Age of first period?

Any other significant problem? ____

Birth History □ Don't know birth history

Birth weight ___________________Was the baby born at term? __________OR __________ weeks
Were there any prenatal or neonatal complications? □Yes □No Explain _________________________________

____
Was a NICU stay required? □Yes □No Explain ____
During pregnancy, did mother: Use tobacco □Yes □No Drink alcohol □Yes □No
Use drugs or medications □Yes □No Used prenatal vitamins? ____________________________________
Was the delivery □Vaginal □Cesarean If cesarean, why? _____________________________________
Was initial feeding □Formula □Breast milk How long breastfed? _______________________________
Did your baby go home with mother from the hospital? □Yes □No Explain ____________________________

____

General DK = don't know

Do you consider your child to be in good health? □Yes □No □DK Explain ______________________________
Does your child have any serious illnesses or medical conditions? □Yes □No □DK Explain _____________
Has your child had any surgery? □Yes □No □DK Explain _______________________________________
Has your child ever been hospitalized? □Yes □No □DK Explain __________________________________
Is your child allergic to medicine or drugs? □Yes □No □DK Explain ______________________________
Do you feel your family has enough to eat? □Yes □No □DK Explain ______________________________

Biological Family History DK = don't know

Have any family members had the following?
Childhood hearing loss □Yes □No □DK Who __________ Comments _______________________________
Nasal allergies □Yes □No □DK Who ___________ Comments ____________________________________
Asthma □Yes □No □DK Who ____________ Comments ____
Tuberculosis □Yes □No □DK Who ___________ Comments ____________________________________
Heart disease (before 55 years old) □Yes □No □DK Who ____________ Comments ___________________
High cholesterol/takes cholesterol medication □Yes □No □DK Who ___________ Comments _____________
Anemia □ Yes □No □DK Who ____________ Comments____
Bleeding disorder □Yes □No □DK Who ____________ Comments _________________________________
Dental decay □Yes □No □DK Who ____________ Comments ____________________________________
Cancer (before 55 years old) □Yes □No □DK Who ____________ Comments _______________________
Liver disease □Yes □No □DK Who ____________ Comments ____________________________________
Kidney disease □Yes □No □DK Who ____________ Comments __________________________________
Diabetes (before 55 years old) □Yes □No □DK Who _____________ Comments ______________________
Bed-wetting (after 10 years old) □Yes □No □DK Who ____________ Comments ______________________
Obesity □Yes □No □DK Who ____________ Comments _______________________________________
Epilepsy or convulsions □Yes □No □DK Who ____________ Comments ____________________________
Alcohol abuse □Yes □No □DK Who ____________ Comments __________________________________
Drug abuse □Yes □No □DK Who ____________ Comments_____________________________________
Mental illness/depression □Yes □No □DK Who ____________ Comments ___________________________
Developmental disability □Yes □No □DK Who ____________ Comments ___________________________
Immune problems, HIV, or AIDS □Yes □No □DK Who ____________ Comments _____________________
Tobacco use □Yes □No □DK Who ____________ Comments ___________________________________
Additional family history ____