Patient History Form: Child 11 and under

Name_____

What concerns do you have about your child's health?

Please list any medical problems or diseases your child has had.

Please list any complications or problems with your child's pregnancy and delivery.

Please list any hospitalizations, accidents or injuries your child has had.

Has your child had the chickenpox disease?
YES NO Date: _____
Have they received the immunization?
YES NO Date: _____

Please list any surgeries your child has had.

Please write down all the supplements, prescription or over the counter medicines that your child takes.

Please list the people who live in your child's home and how they are related to your child.

Has your child ever had a reaction or allergy to a medicine?

Please circle if anyone related to your child has had…

Asthma Allergies Seizures High Cholesterol
Heart Disease Cancer Depression Diabetes
High Blood Pressure

Do other medical problems run in their family?

Please circle the following answers.
Does your child:

Drink caffeine (cof/pop/tea)	Y	N	Amt_____
Wear seatbelts	Y	N	Sometimes
Wear bike helmet	Y	N	Sometimes
Exercise regularly	Y	N	Sometimes
Wear sunscreen	Y	N	Sometimes

	Average servings per day:					
…eat fruits	0	1	2	3	4	+
…eat vegetables	0	1	2	3	4	+
…eat meat, eggs or beans	0	1	2	3	4	+
…take dairy products	0	1	2	3	4	+
…eat candy/sweets	0	1	2	3	4	+
…eat breads/cereals	0	1	2	3	4	+

Does anyone smoke at home?	YES	NO
Do you have smoke detectors at home?	YES	NO
Is your water heater set below 130 degrees?	YES	NO
Do you have covers on all outlets?	YES	NO
Are safety locks on all cabinets with chemicals?	YES	NO

Please **CIRCLE** any problems in the last 30 days:

Fevers
Night Sweats
Trouble with Vision
Trouble with Hearing
Racing Heartbeat
Cough
Difficulty Breathing
Abdominal Pain
Decreased Appetite
Constipation
Blood in Stool
Vomiting
Change in Stools
Pain with Urinating
Loss of Urine Control
Skin Rash
Balance
Headaches
Unusually fussy/irritable
Mood Swings