HEALTH HISTORY RECORD

Please answer each question (to be completed by parent or guardian)

Patient's Name:____Age:___________________

Referring Doctor:____________________________Name of Pediatrician:______________________

Other Doctors providing care for your child:____

What is the reason for today's visit?____

____

Medical History: Child's birth weight:________Was your child a premature baby?_____How many weeks?________

Any problems during the pregnancy?____

Any chronic conditions or illnesses?____

Has your child had any surgeries?__________Please list type and approximate dates:_______________

____

Has your child ever been hospitalized for any other reasons?_________Please explain:________________

____

Are immunizations up to date?_______If no, please explain:__________________________________

What grade is your child in (if not in school, are they in daycare or preschool)?______________________

Please list members of the household:____

What is your child's current height/length?________________What is your child's current weight?__________

Family Medical History: ***Please check yes or no if any relatives have or had any of the following illnesses:***

	Yes	No	Family member(s) relation to patient
Ear or Hearing problem	☐	☐	______________________
Cancer	☐	☐	______________________
Bleeding disorder	☐	☐	______________________
Problems with anesthesia	☐	☐	______________________
Heart problem	☐	☐	______________________

Any other illness not listed above?____

Medication History: Does your child have any allergies to medication?___________________________

Any other type of allergies (i.e. food, latex, cats, etc.)?_____________________________________

Please list any prescription and non-prescription medications your child is currently taking:_______________

____

System review: ***Does your child have or ever had any of the following (check all that apply):***

- ❑ Recurrent ear infections
- ❑ Recurrent Strep Throat/Tonsillitis
- ❑ Recurrent Sinusitis
- ❑ Headaches/sinus pain
- ❑ Recurrent Pneumonia
- ❑ Immune Deficiency
- ❑ Unknown Cause of Fever
- ❑ Cystic fibrosis
- ❑ Failure to Thrive
- ❑ Anemia
- ❑ Blood Transfusion
- ❑ Bleeding Disorder
- ❑ Nosebleeds
- ❑ Stuffy Nose
- ❑ Sneezing
- ❑ Runny Nose
- ❑ Itchy/watery eyes
- ❑ Mouth Breathing
- ❑ Loud Snoring
- ❑ Behavior or Mood problems
- ❑ Bedwetting
- ❑ Bad Breath
- ❑ Asthma or Lung problems
- ❑ Heart Problem
- ❑ Kidney or Liver problems
- ❑ Seizures
- ❑ Dizziness/Imbalance
- ❑ Hearing Loss
- ❑ Speech problems
- ❑ Swallowing problems
- ❑ Stomach Acid Reflux
- ❑ Spitting up/vomiting
- ❑ Broken bones
- ❑ Muscle Weakness
- ❑ __________________

I confirm that the above is true and correct to the best of my knowledge (Parents/Guardians please sign below)

Print Name:____________________________Signature:____________________________Date:________

Office use only: Reviewed by: ____________________________________M.D. Date:______________