Medical History Form

Mother/Primary Guardian Occupation _____ **Father/Secondary Guardian Occupation** _____

Are patient's mother and father: Married Separated Divorced

What is the patient's custody status? _____

Are there pets in the household? Yes No

Please explain. _____

Are there any smokers in the home? Yes No

Are th guns in the home? Yes No

Are they safely locked away? Yes No

Family History: Check if a family member has had any of the following...

- ☐ **Allergies**
- ☐ **Anemia/Blood Disorders**
- ☐ **Asthma**
- ☐ **Bladder/Kidney problems**
- ☐ **Cancer**
- ☐ **Deafness**
- ☐ **Diabetes before age 50**
- ☐ **Drug Allergies**
- ☐ **Drug/Alcohol Abuse**
- ☐ **Learning problems/Attention Span**
- ☐ **Emotional/Behavioral Issues**
- ☐ **Epilepsy/Seizures**
- ☐ **Eye or Vision problems**
- ☐ **Heart Attack/Stroke before age 50**
- ☐ **Other Heart problems**
- ☐ **Genetic Disorders**
- ☐ **High Blood Pressure before age 50**
- ☐ **High Cholesterol**
- ☐ **Immunity problems/HIV**
- ☐ **Other** _____
- ☐ **Liver Disease**
- ☐ **Mental Illness**
- ☐ **Mental Retardation**
- ☐ **Obesity**
- ☐ **Respiratory problems**
- ☐ **Stomach/GI problems**
- ☐ **Thyroid/Endocrine problems**
- ☐ **Tuberculosis**
- ☐ **Ear Infections/Ear Tubes**

Development: Are you concerned about the patient's...

Physical development? Yes No

Please explain. _____

Mental or Emotional development? Yes No

Please explain. _____

Learning ability? Yes No

Please explain. _____

Attention span or activity level? Yes No

Please explain. _____

Pregnancy: Check if the mother had any of the following problems.

- ☐ **Excessive Weight Gain**
- ☐ **Urinary Infections**
- ☐ **Excessive swelling**
- ☐ **Hepatitis B**
- ☐ **Rubella**
- ☐ **Venereal Disease**
- ☐ **Diabetes**
- ☐ **Other**
- ☐ **Toxemia**
- ☐ **None**

Did mother use drugs or alcohol during pregnancy? Yes No

Please explain. _____

Birth History

Birth Weight: _____ **Birth Length**: _____

Was born: Term Early Late

How many weeks? _____

Was delivery difficult or complicated? Yes No

Please explain. _____

Newborn History: Check if the patient had any of the following problems...

- ☐ **None**
- ☐ **Colic**
- ☐ **Breastfeeding Issues**
- ☐ **Slow Weight Gain**
- ☐ **Jaundice**
- ☐ **Formula Intolerance**
- ☐ **Blood in Stools**
- ☐ **Recurrent Vomiting**
- ☐ **Recurrent Diarrhea**
- ☐ **Other** _____

Medical History:

Is patient having any medical problems? No Yes

Please explain. _____

Has patient had any past surgeries? No Yes

Please list dates and procedures. _____

Are patient's immunizations up to date? No Yes

Please explain. _____

Please list current medications. _____

Does patient have any drug allergies? No Yes

Please list medications. _____

Does your child eat a healthy, well-balanced diet with veggies and fruits? No Yes

Please explain. _____

Does the patient get at least 1 hour of outdoor activity per day? No Yes

Does the patient sleep at least 8 hours each night? No Yes

How many hours do they sleep each night? _____

Are you concerned about the patient's electronic usage? No Yes

How many hours per day is the patient in front of a screen? _____

Are there any other concerns you have regarding your child? No Yes

Please explain. _____

I,_____ , have reviewed the information on this medical history form and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the doctor. I authorize the insurance company indicated on this form to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Parent/Guardian Signature **Date**