Patient Medical History

Patient Name:_____ **DOB:**_____

Past Medical History: Please check any that apply to your child.

- ☐ ADHD
- ☐ Allergic rhinitis (seasonal allergies)
- ☐ Asthma
- ☐ Bed wetting
- ☐ Bronchiolitis
- ☐ Concussion
- ☐ Constipation
- ☐ Crossed Eyes
- ☐ Eczema
- ☐ Migraines
- ☐ Multiple ear infections
- ☐ Preterm infant
- ☐ Reflux
- ☐ Seizures
- ☐ Urinary Tract Infections
- ☐ Other (please list): _____

Surgical History: Please check any that apply to your child.

- ☐ Adenoids removed
- ☐ Appendix removed
- ☐ Circumcision
- ☐ Hernia repair
- ☐ Hypospadius repair
- ☐ Nasal cauterization
- ☐ PE (ear tubes)
- ☐ Pyloric stenosis repair
- ☐ Strabismus repair
- ☐ Tonsillectomy
- ☐ Other (please list): _____

Current Medications:

Allergies:

Family History: Please check conditions that occur in any relative. Indicate the relationship to your child and the age of onset.

- ☐ ADHD
- ☐ Alcoholism
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Celiac's Disease
- ☐ Congenital hip dysplasia
- ☐ Crohn's Disease
- ☐ Cystic fibrosis
- ☐ Depression
- ☐ Diabetes
- ☐ Drug allergy
- ☐ Eating disorder
- ☐ Heart attack (less than 55 yrs old)
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Learning disability
- ☐ Leukemia
- ☐ Migraine
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Sickle cell trait
- ☐ Sudden Infant Death Syndrome (SIDS)
- ☐ Tuberculosis
- ☐ Ulcerative colitis
- ☐ Other (please list):