

PATIENT NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY

Has your child ever had any of the following:

Serious Injuries or accidents?	☐ Yes	☐ No
Surgeries?	☐ Yes	☐ No
Hospitalizations?	☐ Yes	☐ No
Chickenpox?	☐ Yes	☐ No
Frequent ear or sinus infections?	☐ Yes	☐ No
Pharyngitis/tonsillitis?	☐ Yes	☐ No
Other infectious illnesses?	☐ Yes	☐ No
Allergic rhinitis or other allergy?	☐ Yes	☐ No
Asthma, bronchitis, bronchiolitis, pneumonia, or croup?	☐ Yes	☐ No
Heart problems or heart murmur?	☐ Yes	☐ No
Abdominal pain or GERD?	☐ Yes	☐ No
Constipation requiring doctor's visits?	☐ Yes	☐ No
Bladder or kidney infection, or other urologic problem?	☐ Yes	☐ No
Bed-wetting (after 5 years of age)	☐ Yes	☐ No
Eye conditions or corrective lenses?	☐ Yes	☐ No
Problems w/ ears or hearing?	☐ Yes	☐ No
Chronic or recurrent skin problems (acne, eczema, etc.)?	☐ Yes	☐ No
Anemia or bleeding problems?	☐ Yes	☐ No
Blood transfusions?	☐ Yes	☐ No
Frequent headaches?	☐ Yes	☐ No
Seizures, developmental delays, ADD/ADHD, or other neurologic disorder?	☐ Yes	☐ No
Mental health concerns?	☐ Yes	☐ No
Orthopedic problems?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Thyroid or other endocrine problems?	☐ Yes	☐ No
If female, have menstrual periods started?	☐ Yes	☐ No
If female, any problems w/ periods?	☐ Yes	☐ No
Use of alcohol or drugs?	☐ Yes	☐ No
Emotional problems?	☐ Yes	☐ No
Other significant problems?	☐ Yes	☐ No