



Urgent Medical & Family Care, PA
 102 Pomona Drive Greensboro, NC 27407-1625
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**PATIENT HISTORY
 AGE 0-11 YEARS**

Today's Date _____

Child's Name _____ Date of Birth _____

Is your child allergic to any medicine ? Yes No If yes, what? _____

Where does he/she get immunizations? _____ Are they up to date? Yes No

List any medications your child is currently taking? _____

PAST MEDICAL HISTORY

Was the birth history normal? Yes No If no, explain _____

Any surgeries? Yes No Any Hospitalizations? Yes No

Please check whether your son/daughter ever had any of the following problems:

- | | | | |
|-----------------------------|--------------------------|-----------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Heart Problems | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | TB (Tuberculosis) | <input type="checkbox"/> |
| Bladder or Kidney Infection | <input type="checkbox"/> | Psychological Problem | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | School Problems | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Other | <input type="checkbox"/> |

FAMILY HISTORY

Is there a family history of the following (among blood relatives - parents, grandparents, aunts, uncles, brothers, sisters)?

- | | | | |
|--------------------------------------|--------------------------|------------------------|--------------------------|
| Alcoholism or Drug Abuse | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> |
| Sickle Cell Anemia | <input type="checkbox"/> | TB (Tuberculosis) | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Psychological Problems | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Smoking | <input type="checkbox"/> |
| Heart Attack or Stroke before age 55 | <input type="checkbox"/> | Other | <input type="checkbox"/> |

With whom does the child live with most of the time?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Both parents in same household | <input type="checkbox"/> Brothers |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Sisters |
| <input type="checkbox"/> Father | <input type="checkbox"/> Grandparents |
| <input type="checkbox"/> Guardian | |

Parent/Guardian Signature _____ Date _____