

MEDICAL HISTORY, continued

| | Y | N | Don't Know | DOCTOR'S NOTES |
|---|---|---|------------|----------------|
| Has your child ever been hospitalized overnight? | | | | |
| Has your child ever had surgery? | | | | |
| Does your child have any allergies? To what? | | | | |
| Does your child get regular dental care? | | | | |
| Is your child on any medications? Please list: | | | | |
| Has your child gone to an ER this past year? | | | | |
| Has your child ever had: | | | | |
| Ear infections? | | | | |
| More than 2 strep throats? | | | | |
| Pneumonia | | | | |
| Heart problems? | | | | |
| Chickenpox? | | | | |
| Any major illness? | | | | |
| Reaction to any immunization or medications? | | | | |
| Urinary tract infections? | | | | |
| Wheezing? | | | | |

Family History: Check if close blood relatives have the following:

| Disease | Y | N | Who? | Disease | Y | N | Who? |
|---------------------|---|---|------|---------------------------|---|---|------|
| Asthma | | | | Heart Attack < 50 yrs. | | | |
| Sickle Cell disease | | | | Urine Infections | | | |
| Cystic Fibrosis | | | | Hayfever | | | |
| Tuberculosis | | | | High Blood Pressure | | | |
| Kidney Infections | | | | Anemia Blood Problems | | | |
| Diabetes | | | | Learning Problems | | | |
| Hyperactivity | | | | Seizures | | | |
| Mental Retardation | | | | Emotional Problems | | | |
| Sudden Death | | | | Born w/Heart Problems | | | |
| Birth Defects | | | | Death Shortly After Birth | | | |

School / Daycare Behavior History

Child's school: _____ Grade: _____

| | Y | N | Don't Know | DOCTOR'S NOTES |
|--|---|---|------------|----------------|
| Does child attend special classes or receive special help? | | | | |
| Are you concerned about school behavior problems? | | | | |
| Does your child have problems with: | | | | |
| Frequent nightmares? | | | N/A | |
| Difficult to control? | | | N/A | |
| Fighting a lot? | | | N/A | |
| Trouble making friends? | | | N/A | |
| Bedwetting or stooling problems? | | | N/A | |
| Vision / Hearing? | | | N/A | |
| Appetite? | | | N/A | |

Name of child's previous doctor: _____

Address: _____

Are there any specific issues you would like to discuss with your doctor? _____

Signature of person completing form: _____ Date: _____ Relationship to patient: _____

Reviewed by Dr.: _____ Date: _____