# Medical History Form (Birth-14 years of Age)

First Name: ______________________________ Last Name: ____________________________________

Does your child have any of these complaints or concerns? ✓ if yes

| | | | |
|---|---|---|---|
| ☐ Abdominal Pain | ☐ Cough | ☐ Fever | ☐ School Problems |
| ☐ Anxiety | ☐ Depression | ☐ Headache | ☐ Shortness of Breath |
| ☐ Attention Deficit | ☐ Diarrhea | ☐ Growth Concerns | ☐ Sore Throat |
| ☐ Back Pain | ☐ Dizziness | ☐ Joint Pain | ☐ Swollen Glands |
| ☐ Behavioral Problems | ☐ Earache | ☐ Mole Changes | ☐ Urinary Frequency |
| ☐ Chest Pain | ☐ Excess Thirst | ☐ Nasal Congestion | ☐ Vomiting |
| ☐ Chills | ☐ Excess Weight Gain | ☐ Nausea | ☐ Weight Loss |
| ☐ Constipation | ☐ Fatigue | ☐ Rash | ☐ Wheezing |

Please list all previous medical problems: ☐ None

______________________________________________________________________________

______________________________________________________________________________

Please list any surgeries or medical procedures that your child has had (include dates): ☐ None

______________________________________________________________________________

______________________________________________________________________________

Does your child have any allergies to medication? ☐ No ☐ Yes
If yes, please list the specific medication(s) and the type of reaction that occurred:

______________________________________________________________________________

Please list diseases which run in your family (include relationship, e.g. Mother, Father etc.):

______________________________________________________________________________

What best describes your child's current living environment?
☐ Lives with Mother ☐ Lives with Father ☐ Lives with both parents

☐ Other (please describe) : ________________________________________________________

Please list any current medications that your child takes ( include dose and frequency): ☐ None

______________________________________________________________________________

______________________________________________________________________________

Is your child up to date with their required immunizations? ☐ No ☐ Yes