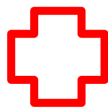

CALVARY MEDICAL CLINIC

Family Practice----Internal Medicine----Pediatrics

*New Patient Medical History Questionnaire (**CHILD**)*

DATE:________________

Mother's Name:__________________ Age:_____ Child's Name:____________________________
Occupation:_______________________ Child's Birth date:_____________________ Age:__________
Father's Name:______________________ Age:________ Who does the child live with?:___________
Occupation:____
Who cares for the child on a regular basis?:____

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Pregnancy and Birth:
Mother age at birth:________
Any illnesses during pregnancy: Yes No
Baby's birth weight ________
Did the baby have any trouble at birth: Yes No
If yes, what kind:__________________________
____

Past Medical History:
Where has your child gone for check ups until now?
____
Date of last Well Child Check Up:_______________
Date of last dental check up:____________________
Allergies to medicine?_________________________
Allergies to food?_____________________________
Any serious injuries?__________________________
Any Hospitalizations?_________________________
For what condition?___________________________
Current Medications:__________________________
____
____
____
____

Family History:
List names, ages, sex of child', brothers and sisters
____

Review of System: Has your child had any of the following problems? If so please circle:
Recurrent ear infections or Sore throats Teeth Problems
Eye problems Asthma Heart Murmur Wheezing
Frequent urination or recurrent: diarrhea Seizures
Skin problems:

Development and Behavior:
At what age did your child sit up alone:________________
At what age did your child start walking:______________
At what age did your child start talking:_______________
How does your child compare to others at his/her age:
____
____
What grade is your child in?_____________________
Any problems in school?________________________
____

Circle any problems your child has had: Biting others nail biting thumb sucking bed wetting bad temper Nightmares Hyperactivity speech problems sleep-walking discipline difficulty

Safety and Environment:
Do you live in an apartment, mobile home, house?
What setting is your water heater on:___________
How hot is your water:___________
Are there working smoke alarms in the home: Yes No
Are there any problems with your home?_________________
Peeling paint insects rats mice other:________________

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Feeding and Nutrition:
Is your child's appetite good? Yes No
Did your child have colic or other feeding problems the first 3 months of life? Y/N
Was the child: Breast fed bottle fed both
If the child was/is on formula what brand is it:____
Does the child take vitamins? Yes No
Any additional health history:____
____
____
____

IF PATIENT IS A MINOR: I,_______________________GIVE MY PERMISSIOIN FOR _______________________ OR____________________________OR____________________________________TO SEEK MEDICAL ATTENTION FOR MY CHILD .

___________________________________ ___________________________________
Printed Name: Signature:

2019