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

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

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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:

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

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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

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