CHILD MEDICAL HISTORY

Date:_____

_____
Last Name **First Name** **Middle Name**

_____
Date of Birth **Sex/ Gender** **Country of Birth** **Social Security Number**

_____
Mother's Name **Father's Name** **Pharmacy Name | Phone Number**

_____
Home Address **City** **State** **Zip Code** **Phone Number**

_____
Emergency Contact Name **Relationship** **Phone Number**

_____
Primary Medical Insurance **Subscriber's Name** **ID/Policy#** **Group#**

_____
Secondary Medical Insurance **Subscriber's Name** **ID/Policy#** **Group#**

Can the physician or staff leave test result information (non-urgent) on your answering machine? YES NO

ALLERGIES TO MEDICATIONS: None

BIRTH HISTORY:

Was your child born: on time, more than one month early, or late? _____

Were there any complications with the pregnancy or delivery? YES NO_____

Were there any problems after birth? YES NO _____

Type of delivery: Vaginal C-Section

At birth what was your child's: Weight _____ Length _____ APGARS _____

Breast fed/ Bottle fed/ Both? _____

PAST/PRESENT MEDICAL PROBLEMS: None _____
_____

SURGERIES/ HOSPITALIZATIONS: None _____

_____

MEDICATIONS: □**None**_____
_____

FAMILY HISTORY:
Has any member of your child's family (Grandparents, Parents, Siblings) ever had the following?

	YES	NO	Relationship		YES	NO	Relationship
Asthma				High Cholesterol			
Arthritis				Kidney Disorder			
Blood Disorder				Seizure			
Cancer				Stomach Disorder			
Diabetes				Stroke			
Drug Abuse				Thyroid Disorder			
Heart Problems				Tuberculosis			
High Blood Pressure				Other:			

SIBLING'S NAMES/ AGES:

SOCIAL HISTORY:

Are there any smokers in the home? □YES □NO
Is your child in daycare? □YES □NO
Do you have city water/ well water?

OTHER QUESTIONS OR CONCERNS:

_____ _____
Parent's Signature **Date**