

**Medical History Questionnaire**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: M / F Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications \*\*Turn over page if more space needed Dose Frequency**

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**Pharmacy choice and location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies & Please describe reaction (Medication, Food or otherwise):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**As far as you know, are your child’s immunizations up to date? Y/N**

**If your child is less than 1 year old, please fill out:**

Birth Weight:\_\_\_\_\_\_\_\_\_Born at Term: Y/N If no, how many weeks:\_\_\_\_\_\_\_\_ Birth Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:** Please indicate with X if your child has had any of the below, **and then explain below:**

\_\_\_\_Asthma/Allergies \_\_\_\_Heart or Lung condition \_\_\_\_\_Headaches

\_\_\_\_\_Neurological condition ie seizure \_\_\_\_\_Diabetes \_\_\_\_\_Concussion

\_\_\_\_Anemia or blood disorder \_\_\_\_\_Recurrent infections ie ear \_\_\_\_\_Injuries ie fracture

\_\_\_\_\_Constipation or abdominal condition \_\_\_\_\_Skin Conditions ie Eczema \_\_\_\_\_Urinary or Bladder Conditions

\_\_\_\_\_Eye Condition \_\_\_\_\_Genetic Conditions \_\_\_\_\_Infectious Diseases ie Tuberculosis

\_\_\_\_\_Ear Condition \_\_\_\_\_Developmental Delays \_\_\_\_\_Thyroid Disorder

\_\_\_\_\_Bone Disorders ie scoliosis \_\_\_\_\_Sleep Problems ie snoring \_\_\_\_\_Anxiety or Depression

\_\_\_\_\_Cancer (list below) \_\_\_\_Other (list below)

**Please explain any of the above marked with an “X**”:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgeries (If yes, please provide date, location, and type of surgery):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations: (If yes, please provide date, location, and reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximate date of last Well Child Check:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Immunizations up to date: Yes/No**