

Patient History Form - 6 year and Up

Patient Name _____ DOB _____

Sex M F History given by _____ Date _____

Patient Information:

Are immunizations up to date? Yes or No

Acute Illness / Chronic Illness / Medical Issues / Mental Health Issues:

List all past and present diagnoses

Hospitalizations or ER Visits: List any that have occurred since the last well check

Surgeries: List any that have occurred since the last well check

Allergies: _____

Medications: name, dose, what is it given for?

Social History:

Who does the patient live with?

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: _____

Is your child exposed to tobacco smoke? _____

Any recent travel since the last well check? Yes No Where? _____

Family History - Does anyone in the patients immediate family have any of the following:

Heart Problems/ Heart Attack	Y	N	Migraines/Headaches	Y	N	Allergies	Y	N
High Cholesterol	Y	N	ADHD/ADD	Y	N	Eczema	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Depression or Anxiety	Y	N
Asthma	Y	N	Thyroid Problems	Y	N	Obesity	Y	N
Stomach Problems	Y	N	Bleeding or Clotting Problems	Y	N	Alcoholism	Y	N
Kidney/Bladder Problems	Y	N	Anemia	Y	N	Drug Abuse	Y	N
Seizures	Y	N	Arthritis	Y	N	Cancer	Y	N