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Patient History Information

Age 5 years to 17 years

Date _____

Patient Name _____ Date of Birth _____

Mother's Name _____ Occupation _____

Father's Name _____ Occupation _____

Name of School _____

After School Care _____

Preferred Pharmacy for prescriptions:_____

Past Medical History

Where has your child gone for check-ups until now? _____

Serious illness or injury _____

Hospitalizations/operations _____

Current medications _____

Allergies to medications/other _____

Up to date on immunizations? _____

Has your child had problems with:

eyes ☐ ears ☐ teeth ☐ schoolwork ☐
asthma ☐ chronic cough ☐ behavior ☐ urination ☐
bowel habits ☐ seizures ☐ skin rashes ☐ anemia ☐

Family History

Who lives in the home? _____

Are parents: single ☐ married ☐ divorced ☐ living together ☐

Sibling's name _____ DOB _____ Healthy? _____

Sibling's name _____ DOB _____ Healthy? _____

Sibling's name _____ DOB _____ Healthy? _____

Do any close relatives (mom, dad, siblings, grandparents) have:

asthma/allergies ☐ cystic fibrosis ☐ heart disease ☐ stroke ☐
high cholesterol ☐ birth defects ☐ bleeding disorders ☐ sickle cell ☐
high blood pressure ☐ diabetes ☐ emotional problems ☐ seizures ☐
Irregular heart rate ☐

Safety/Environment

Do you live in a : house ☐ apartment ☐ mobile home ☐ other _____

Is there a working smoke detector on each floor of your home? _____

Are seatbelts always used when riding in a car? _____

Does anyone in the home smoke? _____

Are there problems with the condition of the home? (peeling paint, insects, rodents) _____

Does your child always wear a helmet when riding a bike? _____

Does your child wear other safety equipment: pads, etc? _____