5 YEARS AND UP

Date:_____ Name_____ DOB:_____

Pharmacy:_____

Patient's Past Medical History

Prior Testing/ Developmental Test	None	Yes	Test:_____
Allergies	No	Yes	Date_____
History of Chicken Pox	No	Yes	
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Ear Disorder	No	Yes	
Eye Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth. Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU / Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric / Learning Disorder	No	Yes	
Respiratory Disease / Asthma	No	Yes	
Skin Disease	No	Yes	
History of injury / trauma	No	Yes	

Other Chronic Problems: _____

_____

Family Medical History

Please List Family Member & Details Below

Bleeding Disorder	No	Yes	
Cancer	No	Yes	
Diabetes	No	Yes	
Congenital Heart Disease	No	Yes	
Heart Disease before 50	No	Yes	
Eye Disorder	No	Yes	
Ear Disorder	No	Yes	
Respiratory Disorder	No	Yes	
GI Disorder	No	Yes	
GU Disorder	No	Yes	
Musculoskeletal Disorders	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric Disorder	No	Yes	
SIDS	No	Yes	
Skin Disease	No	Yes	
Other	No	Yes	

Patient Smoking Status (13 years & Over) (Circle one)

Current Everyday Smoker | Current Sometimes Smoker | Former Smoker
Never Smoked | Smoker, current status unknown | Unknown if ever smoked

			Details
Non-Surgical Hospitalizations	None	Yes	
Surgical History	None	Yes	
Ear Surgery	None	Yes	
Nose / Mouth /Throat Surgery	None	Yes	
Respiratory Surgery	None	Yes	
Cardiovascular Surgery	None	Yes	
GI Surgery	None	Yes	
GU Surgery	None	Yes	
Eye Surgery	None	Yes	
Orthopedic Surgery	None	Yes	
Plastic Surgery	None	Yes	
Other Surgery	None	Yes	

Child Social History

Parent Information: (Circle all that apply)

Parents Together | Father Involved | Guardian Parents
Lives with Mother | Mother Involved | Same Sex Partners
Lives with Father | Mother Not Involved | Other:
Father Not Involved | Mother / Father Deceased

Child Care: (Circle all that apply)

Name of Daycare: _____
Home with Parents
Private Home Daycare
Sitter to Home
Family Day Care
Other: _____

Home Occupants: (list all) _____

Parents Smokers: (Circle One)

No Yes Outside Only

Pets? What type? Inside or Outside? How many?_____

Extracurricular Activities: (sports, music, etc.) _____

Educational/ School Information

Name of School:_____
Grade: _____
School Performance: (circle all that apply)

Likes School | Dislikes School | Advanced Program | Honor Roll
Excellent | Good | Fair | Poor

School Issues: (circle all that apply)

None | Behavior Problems | Peer Problems | Non Attendance
Expelled | Suspended | Referred for ADHD testing by school

Menstrual History: (female only)

Age at First Menstrual Cycle: _____ Regular?_____
Cycle Length: _____ Amount of Flow?_____