ORION Family Physicians

CHILD MEDICAL HISTORY FORM

NAME_____ D.O.B_____

MEDICAL HISTORY

	Y	N
ASTHMA		
ALLERGIES (SEASONAL)		
CHRONIC EAR INFECTION		
ADD/ADHD		
ECZEMA/DERMATITIS		
SEIZURE HISTORY		
HEART PROBLEMS		

OTHER CONDITIONS NOT LISTED ABOVE

_____

SURGICAL HISTORY

TYPE	DATE

ALLERGIES: NONE OR _____

MEDICATIONS

PLEASE INCLUDE OVER THE COUNTER MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS

MED	DOSE	TIMES TAKEN/DAY

ARE YOUR CHILDS IMMUNIZATIONS UP TO DATE TO THE BEST OF YOUR KNOWLEDGE? YES OR NO

BIRTH/NEWBORN HISTORY

VAGINAL OR C-SECTION

PREGNANCY OR DELIVERY COMPLICATIONS: NO OR YES
IF YES, WHAT? _____

BIRTH WEIGHT: _____LB_____OZ

FEEDING: BREAST FORUMLA BOTH

NEONATAL PROBLEMS: JAUNDICE BREATHING PROBLEMS HEART PROBLEMS

FAMILY HISTORY

	Y	N	RELATIVE (MOTHER, FATHER, SISTER, BROTHER, GRANDMOTHER, GRANDFATHER, CHILD)
ASTHMA			
DIABETES			
HEART DISEASE (CLOGGED ARTERIES)			
HEART ATTACK (INCLUDE AGE)			
HIGH CHOLESTEROL			
HIGH BLOOD PRESSURE			
THYROID PROBLEMS			
CANCER (WHAT TYPE)			
STROKE			
ALZHEIMERS			
DEPRESSION/ANXIETY			
MIGRAINE			

SOCIAL HISTORY

WHO LIVES IN THE HOME WITH YOUR CHILD? _____

DOES YOUR CHILD ATTEND DAYCARE? YES OR NO

IS YOUR CHILD EXPOSED TO ANY SECONDHAND SMOKE? YES OR NO

DO YOU HAVE ANY PETS? YES OR NO

DOES YOUR CHILD HAVE ANY EATING DIFFICULTIES? YES OR NO

WHERE DOES YOUR CHILD ATTEND SCHOOL AND WHAT GRADE ARE THEY IN?_____

DOES YOUR CHILD PARTICIPATE IN EXTRA-CURRICULAR ACTIVITIES: YES OR NO

FOR OUR TEENAGERS (12 AND UP)

DO YOU SMOKE? NO OR YES

DO YOU OR HAVE YOU EVER DONE ILLICIT DRUGS? NO OR YES

DO YOU EXPERIENCE PEER PRESSURE ABOUT DRUGS, ALCOHOL, OR SEX THAT YOU HAVE TROUBLE DEALING WITH? NO OR YES

DO YOU EVER FEEL ANXIOUS OR DEPRESSED? NO OR YES

FEMALES ONLY
HAVE YOU HAD A MENSTRUAL CYCLE YET? YES OR NO
IF YES, ARE THEY REGULAR? YES OR NO