PATIENT HEALTH HISTORY

Child's Name: _____ Date of Birth: _____

HISTORY	MOTHER	FATHER	SISTER(S)	BROTHER(S)	PATIENT
ADD or ADHD					
ALLERGIES					
ASTHMA					
BLEEDING DISORDERS					
CANCER (PLEASE SPECIFY)					
DEPRESSION					
DIABETES					
EAR INFECTIONS					
HEADACHES OR MIGRAINES					
HEARING LOSS					
HYPERTENSION					
HYPERLIPIDEMIA					
HEART DISEASE					
KIDNEY DISEASE					
SEIZURE DISORDER					
SINUS INFECTIONS					
SNORING OR SLEEP APNEA					
TONSIL INFECTION					
THYROID DISEASE					
BIRTH DEFECTS					
OTHER					

Has your Child had any previous Hospitalizations/Surgeries or any Serious Illnesses? If yes, please explain: _____

_____

Does your Child have any medication or other Allergies:

- ☐ No known medication or other Allergies
- ☐ Yes. Name: _____
  Name: _____
  Name: _____

Is your Child currently taking any Medications?

- ☐ Not currently taking any medications
- ☐ Yes Name: _____ mg
  Name: _____ mg
  Name: _____ mg
  Name: _____ mg
  Name: _____ mg