PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

Medical History		Please provide details for any yes answers
Has your child had any allergic reactions to medications?	Y N	
Has your child had any allergic reactions to food or other items?	Y N	
Does your child take any medications on a daily basis?	Y N	
Does your child follow a special diet? (Vegetarian, gluten-free, etc.)	Y N	
Does your child have any medical conditions? (Asthma, seasonal allergies, heart problems, GER, developmental delay, etc.)	Y N	
Does your child see any specialists?	Y N	
Has your child had any serious injuries?	Y N	
Has your child had any surgeries?	Y N	
Has your child ever been hospitalized overnight?	Y N	
Are your child's immunizations up to date? Date of last well-child checkup_____	Y N	

Family and Social History	
What medical conditions do family members have? Who has them? (Ex. allergies, asthma, early heart disease, kidney problems, early unexpected death)	
What are the occupations of the adults living at home?	
Who lives at home?	
What types of animal or pets do you have?	
Does anyone at home smoke?	
Are there any guns in the home? If so, are they locked up?	