PATIENT INFORMATION SHEET CHILD

Name:_____ Birthdate:_____

Parents' names: _____

Who is your legal guardian? Mom Dad Other: _____

BIRTH HISTORY: Delivery: Natural cesarean section Any complications to pregnancy?_____

Birth weight: _____ Any problems during newborn period? _____

MEDICAL HISTORY: List any current or past medical problems or chronic diseases.

_____

_____

_____

SURGICAL HISTORY: List all surgeries you have had, the year they were done, and the surgeon's name.

_____

_____

MEDICATIONS: List all medicines taken daily, with dose and schedule. Include over the counter meds, vitamins and supplements.

Name of Medication	Strength/Dose (mg)	How often taken	Reason you are taking

ALLERGIES: List all allergies to medicines or foods and the kind of a reaction you have - rash, hives, swelling, difficulty breathing, etc.

_____

_____

List any other physicians you see and why: _____

_____

HEALTH MAINTENANCE: Any second hand smoke? _____

What do you do for exercise, and how often?_____

Are you on a special diet?_____ Describe your typical eating habits:_____

How much caffeine do you drink in a typical day? None_____ 1-2 drinks_____ 3-4 drinks _____ 5 or more drinks_____

How frequently are you in the sun? _____ Do you wear sunscreen? _____ Do you use a tanning bed? _____

Who lives in your home and what is their relationship to you? _____

_____

Hobbies or other special interests: _____

How often do you wear your seatbelt? Always _____ Sometimes _____ Never _____

How much TV do you watch? _____ How much video game/computer time? _____

What grade are you in? _____ What school do you attend? _____

Any pets? (inside/outside) _____

FAMILY HISTORY: Are your parents alive? _____ If not, what did they die from, and how old were they?

Mother:_____ Father:_____

Which of your blood relatives have had the following diseases? (Check all that apply.)

	Mother	Father	Brother	Sister	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Aunt	Uncle
Heart disease										
High blood pressure										
Asthma										
Stroke										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Prostate Cancer										
Uterine Cancer										
Alcoholism										
Anxiety										
Depression										
Diabetes										
Other Conditions										

PREVENTATIVE HISTORY: Last well child exam: _____ Last eye exam: _____

Last dental exam: _____ Last flu shot_____ Tetanus booster: _____

Are your immunizations up to date? (Please provide copy of record)_____

FEMALE HISTORY: Last menstrual period: _____ Age of first period: _____

Any menstrual problems: _____