MODIFY

Child Medical History

Date: _____

Patient Name: _____ _____ DOB: _____

Age: _____ Gender: _____ Height: _____ Weight: _____

Person Completing Questionnaire: _____

Relationship to Patient: _____

1. Current Medical Problems:

a. *What symptoms made you seek treatment? _____*
_____

b. *Has there been any change in your child's general health within the last year? Yes____ No____*

If yes, please describe: _____
_____

c. *When was your child's last physical examination? _____*

d. *What is the name and phone number of your child's primary care physician?*
_____
_____

e. *Has your child had any serious illnesses, operations, medical or psychiatric hospitalizations?*
Yes _____ No _____ If yes, please describe:
_____
_____

2. Medications:

Please list any current medications your child is currently taking, along with the reason:
_____
_____

3. Past Medical History:

Has your child had any of the following medical procedures:

CT scan (head)	*Yes_____*	*No _____*	*Age_____*
MRI scan (head)	*Yes _____*	*No _____*	*Age _____*
EEG (head)	*Yes _____*	*No _____*	*Age _____*
EKG (heart)	*Yes _____*	*No _____*	*Age _____*

Has your child had any of the following medical conditions and, if so, at what age?

High Fevers	*Yes _____*	*No _____*	*Age_____*
Ear Infections	*Yes _____*	*No _____*	*Age _____*
Head Trauma	*Yes _____*	*No _____*	*Age _____*
Loss of Consciousness	*Yes _____*	*No _____*	*Age _____*
Seizures	*Yes _____*	*No _____*	*Age _____*
Obesity	*Yes _____*	*No _____*	*Age _____*
Headaches	*Yes _____*	*No _____*	*Age _____*
Broken Bones	*Yes _____*	*No _____*	*Age _____*
Heart Problems	*Yes _____*	*No _____*	*Age _____*
Lung Problems	*Yes _____*	*No _____*	*Age _____*
Bowel Problems	*Yes _____*	*No _____*	*Age _____*
Stomach Problems	*Yes _____*	*No _____*	*Age _____*
Urinary Problems	*Yes _____*	*No _____*	*Age _____*
Allergies	*Yes _____*	*No _____*	*Age _____*
Asthma	*Yes _____*	*No _____*	*Age _____*
Hearing Problems	*Yes _____*	*No _____*	*Age _____*
Eye Problems	*Yes _____*	*No _____*	*Age _____*
Surgeries	*Yes _____*	*No _____*	*Age _____*

If you answered yes to any of the above, please specify:

_____

_____

Has your child been seen by a neurologist? Yes _____No _____ If so, for what reason? _____

_____

Is your child allergic to any drugs? Yes _____ No _____ If so , please list them: _____

_____

Other Conditions:

Does your child have problems with concentration or attention?	*Yes _____*	*No _____*
Does your child have any problems with hyperactivity?	*Yes _____*	*No _____*
Does your child have any sleep problems?	*Yes _____*	*No _____*
Does your child have any eating problems?	*Yes _____*	*No _____*
Does your child wet the bed?	*Yes _____*	*No _____*
Does your child soil themselves?	*Yes _____*	*No _____*

Do you believe that your child uses any of the following: (check all that apply)

Recreational Drugs	*Yes _____*	*No _____*
Alcoholic Beverages	*Yes _____*	*No _____*
Caffeinated Drinks	*Yes _____*	*No _____*
Cigarettes	*Yes _____*	*No _____*

If you checked yes to any of the above, please describe:

_____

_____