



**New or Updated Children & Adolescent Patient Medical History  
(16 years or younger)**

**Patient Name:** \_\_\_\_\_

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**SOCIAL HISTORY**

	Yes	No		Yes	No
Day Care/Pre-School	_____	_____	Bottle Fed as Infant	_____	_____
Family Smoking	_____	_____	Breast Fed as Infant	_____	_____
Is Your Child Adopted	_____	_____	Using Pacifier	_____	_____
Are Parents Divorced	_____	_____			

**INDICATE BELOW ANY DISEASES YOUR CHILD MAY HAVE:** (if yes, explain below)

	Yes	No		Yes	No
Eye Disease	_____	_____	Bleeding Tendency	_____	_____
Lung Disease	_____	_____	Rheumatic or Scarlet Fever	_____	_____
Heart Disease	_____	_____	Eczema	_____	_____
Kidney Disease	_____	_____	Diabetes	_____	_____
Urinary Disease	_____	_____	Frequent Infections (lungs, urinary, etc)	_____	_____
Thyroid Disease	_____	_____	Elevated Bilirubin	_____	_____

**LIST ANY OTHER DISEASES YOUR CHILD MAY HAVE HAD:**

\_\_\_\_\_  
\_\_\_\_\_

**SURGERIES:** (List below any surgery your child has had):

\_\_\_\_\_  
\_\_\_\_\_

**PROBLEMS WITH GENERAL ANESTHESIA?** (circle one) Yes No

**ARE YOUR CHILD'S IMMUNIZATIONS CURRENT?:** (circle one) Yes No

**LIST THE CURRENT MEDICINES YOUR CHILD IS TAKING:** (List with Dosage and Frequency)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**KNOWN ALLERGIES TO: ENVIRONMENT: Yes No FOOD: Yes No**

**KNOWN ALLERGIES TO MEDICATION: Yes No** (If yes, list below)

\_\_\_\_\_

**BIRTH HISTORY:** (if abnormal, explain below) Yes No Yes No

Normal Full Term Pregnancy	_____	_____	ICU Hospitalization Immediately		
Normal Labor	_____	_____	After Birth	_____	_____
Normal Vaginal Delivery	_____	_____	Weight At Birth _____		

**FAMILY HISTORY:** INDICATE BELOW ANY DISEASE IN YOUR CHILD'S IMMEDIATE FAMILY (Parents, Brothers, Sisters)

	Yes	No		Yes	No
Hearing Loss	_____	_____	Allergies	_____	_____
Bleeding Abnormalities	_____	_____	Anesthesia Complications	_____	_____

**LIST ANY ABNORMAL BIRTH DEFECTS OR BIRTH CONDITIONS:** \_\_\_\_\_

\_\_\_\_\_

*The above information is correct.*

**Parent Signature:** \_\_\_\_\_