Medical History for Child

Today's Date:_____Sex:_____M, _____F

Name:_____Date of Birth:_____

Race CIRCLE One: Caucasian – Chinese – Asian – African-American – Hispanic – Other_____

Allergies to Medication, X-Ray Dyes, or other substances:_____YES, _____NO

What medication/what reaction: _____

Past Medical History: Please CIRCLE if YOU have had problems with or are presently complaining of any of the following:

Abdominal pain	Allergic rhinitis/Hay fever	Congenital defect
Anemia	Arthritis-rheumatoid	Asthma
Diarrhea-chronic	Gall bladder disease	Seizure
Headache	Hepatitis	Diabetes type I or II
Constipation-chronic	Rash	Other:
Kidney stone	Chicken Pox	_____
Urinary tract infection	Measles	_____
Fracture		_____

Please list and supply the dates of:

Operations:_____
_____
Hospitalizations other than for surgery:_____
_____

Immunization history – When was the last time you had the following vaccines:

Hepatitis B_____ Hepatitis A_____
MMR(measles,mumps, rubella)_____, Td_____
DTaP(diphtheria,tetanus,pertussis)_____Polio_____

When was your last: Complete Physical Exam_____
Eye Exam_____

Any abnormal reports: _____

Medications that you take (prescription, over the counter, vitamins, herbs, etc).

Drug Name	Dose & Frequency	Drug Name	Dose & Frequency
_____		_____	
_____		_____	

Prevention/Social History:

Ever worked or been exposed to ____Asbestos, ____Hepatitis, ____Tuberculosis,____Toxic chemicals
Wear seatbelts while in the car? ____Always, ____Usually, ____Never
Wear a helmet while riding a bike? ____Always, ____Usually, _____Occasionally, ____Never

What grade are you in at school?_____

Family History: Has any member of your family (parents, grandparents, & siblings) ever had the following?

ILLNESS **WHICH FAMILY MEMBER**

Cancer (type)_____

High blood pressure_____

Heart attack/Angina_____

Diabetes Type I or II _____

Stroke_____

Mental disease_____

(anxiety, depression, etc.)

Drug/alcohol abuse_____

High Cholesteral_____

Other:_____

Circle any of the following problems that may have affected you recently.

General: weight gain, weight loss, fever, feeling of tiredness.

Skin: change in skin lesions, excessive hair growth, rash, severe acne, skin lumps, easy bruising.

Head, Eyes, Ears, Nose & Throat: head injury, earaches, nose bleeds, lumps in the neck, swollen glands.

Lungs: persistent cough, coughing up blood or sputum, chronic shortness of breath, shortness of breath on exertion, wheezing.

Heart: heart murmur, difficult breathing while lying down, irregular heartbeats.

Gastrointestinal: nausea or vomiting, black or bloody stools, persistent diarrhea, yellow skin, constipation, abdominal pain.

Muscle-Skeletal: joint pains, muscle pains, joint redness or swelling.

Neurologic: seizures, tremor.

Is there anything else you would like Dr. Zhou or staffs to know about yourself?

NO_____

YES_____

_____