

PAST MEDICAL HISTORY

Patient Name: _____ DOB: _____

BIRTH:

Born at _____ weeks gestation

PAST MEDICAL HISTORY:

- | | |
|--|---|
| <input type="checkbox"/> Complicated Birth | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Complicated Delivery | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Abuse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lice |
| <input type="checkbox"/> Breathing Treatments | <input type="checkbox"/> STD |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Frequent Strep |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> ADHD |

Other:

Surgeries:

Hospitalizations: (reason, year)

MEDICATION:

Current Medications:

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____

Drug Allergies:

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____