Patient''s Name _____________________________ Date of birth __________

Please fill this form out completely to the best of your knowledge. If you have any questions, please ask your nurse.

Patient's Past Medical History

Does your child have or ever had?

Anemia (sickle cell, iron deficient, etc.) ☐ Yes ☐ No Explain / Comments ___________________________________
Asthma, bronchitis, pneumonia ☐ Yes ☐ No Explain / Comments ___________________________________
ADHD (or other behavioral diagnosis) ☐ Yes ☐ No Explain / Comments ___________________________________
Bed wetting (after 5 years of age) ☐ Yes ☐ No Explain / Comments ___________________________________
Bleeding disorder (hemophilia, etc) ☐ Yes ☐ No Explain / Comments ___________________________________
Chickenpox ☐ Yes ☐ No When ____
Frequent belly pain ☐ Yes ☐ No Explain / Comments ___________________________________
Constipation requiring a doctor visit ☐ Yes ☐ No Explain / Comments ___________________________________
Problems with eyes or vision ☐ Yes ☐ No Explain / Comments ___________________________________
Diabetes ☐ Yes ☐ No Explain / Comments ___________________________________
Problems with ears or hearing ☐ Yes ☐ No Explain / Comments ___________________________________
Any heart problems or heart murmur ☐ Yes ☐ No Explain / Comments ___________________________________
Frequent ear infections ☐ Yes ☐ No Explain / Comments ___________________________________
Frequent headaches / migraines ☐ Yes ☐ No Explain / Comments ___________________________________
(for girls) Has she started her period ☐ Yes ☐ No When ____
(for girls) Any problems with periods ☐ Yes ☐ No Explain / Comments ___________________________________
Blood transfusion ☐ Yes ☐ No Explain / Comments ___________________________________
Seizures or other neurologic problems ☐ Yes ☐ No Explain / Comments ___________________________________
Chronic skin problems (eczema, acne) ☐ Yes ☐ No Explain / Comments ___________________________________
Use of alcohol or drugs ☐ Yes ☐ No Explain / Comments ___________________________________
Use of tobacco (smoking, dipping, etc) ☐ Yes ☐ No Explain / Comments ___________________________________
Thyroid or growth problems ☐ Yes ☐ No Explain / Comments ___________________________________
Urinary Tract Infection ☐ Yes ☐ No Explain / Comments ___________________________________
Other medical history not listed ☐ Yes ☐ No Explain / Comments ___________________________________

Patient's Past Surgical History

Did your child have any of the following surgeries?

Appendix removed ☐ Yes ☐ No When ____
Ear tubes ☐ Yes ☐ No When ____
Tonsils or adenoids removed ☐ Yes ☐ No When ____
Any other surgeries ☐ Yes ☐ No When ____________ Comments ___________________________

Patient Allergy History

Does your child have allergies to any of the following?

Bee Stings ☐ Yes ☐ No Reaction ____
Cow's Milk ☐ Yes ☐ No Reaction ____
Latex ☐ Yes ☐ No Reaction ____
Peanut ☐ Yes ☐ No Reaction ____
Penicillin ☐ Yes ☐ No Reaction ____

Sulfa Medications ☐ Yes ☐ No Reaction ____

Other ☐ Yes ☐ No What substance _______________ Reaction ___________________

Family History

Have any family members (brother, sister, mom, dad, grandparents) had the following?

Condition	Yes	No	Who	Comments
Allergies (seasonal, drug, food)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Anemia (sickle cell, etc)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Asthma	☐ Yes	☐ No	Who _______________	Comments ______________________________
Bed wetting (after age 10)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Bleeding disorder (hemophilia, etc)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Complete deafness (hard of hearing)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Diabetes “sugar” (before age 50)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Seizures (as an infant, child or adult)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Heart disease (before age 50)	☐ Yes	☐ No	Who _______________	Comments ______________________________
High blood pressure (before age 50)	☐ Yes	☐ No	Who _______________	Comments ______________________________
High cholesterol	☐ Yes	☐ No	Who _______________	Comments ______________________________
Kidney disease (dialysis)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Liver disease	☐ Yes	☐ No	Who _______________	Comments ______________________________
Mental health disorder (depression, anxiety, etc)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Substance abuse (drugs/alcohol)	☐ Yes	☐ No	Who _______________	Comments ______________________________
Tuberculosis	☐ Yes	☐ No	Who _______________	Comments ______________________________
Any other significant illnesses	☐ Yes	☐ No	Who _______________	Comments ______________________________

Family Social History

Does the family receive:

- **ADC** (Aid to Dependent Children) or **OWF** (OH Workers First) ☐ Yes ☐ No
- **SNAP** (Supplemental Nutrition Assistance Program) - Food Stamps ☐ Yes ☐ No
- **WIC** (Women, Infant, Children assistance) ☐ Yes ☐ No
- **HEAP** (Home Energy Assistance) or
  PIPP (Percentage of Income Payment plan) ☐ Yes ☐ No
- **HMG** (Help Me Grow) ☐ Yes ☐ No

Is the baby / child in daycare? ☐ Yes ☐ No

Does anyone in the household smoke (indoors or outside)? ☐ Yes ☐ No

Are there pets in the house? ☐ Yes ☐ No

Has the family traveled out of state recently? ☐ Yes ☐ No