Medical Pediatrics, Ltd.

Patient Health History

Date: _____

Patient Name: _____ Male / Female DOB: _____
Last First Middle

Patient Health History *(Please list details for all questions answered **YES**)*

Does your child have any chronic health problems? ☐ NO ☐ YES: _____

_____

Does your child have any allergies? ☐ NO ☐ YES: *(Include seasonal allergies, asthma, food, medication reactions, etc.)*

_____

Does your child have any special needs? ☐ NO ☐ YES: _____

Were any developmental or significant medical diagnoses made by other physicians? ☐ NO ☐ YES: _____

_____

Does your child have any difficulties at school? ☐ NO ☐ YES: _____

_____

Does your child receive special services such as speech or physical therapy? ☐ NO ☐ YES: _____

Has your child had a major illness or trama? ☐ NO ☐ YES: _____

Has your child ever been hospitalized? ☐ NO ☐ YES: _____

Has your child had any surgeries? ☐ NO ☐ YES: _____

Does your child take any prescriptions, over the counter medicines, homeopathics or supplements? ☐ NO ☐ YES:

_____

Is your child on a special diet? ☐ NO ☐ YES: _____

_____

Does your child participate in organized sports?	☐ NO	☐ YES	Has your child had Chicken Pox?	☐ NO	☐ YES
Does your child have frequent ear infections?	☐ NO	☐ YES	Has your child ever had Tonsillitis?	☐ NO	☐ YES
Has your child ever had difficulty breathing?	☐ NO	☐ YES	Had Tonsils & Adenoids removed?	☐ NO	☐ YES
Was your house / apartment built before 1960?	☐ NO	☐ YES	Has your child ever had Pneumoni:	☐ NO	☐ YES
Are you on a City water supply (Flouridated)?	☐ NO	☐ YES	Does your child have difficulty falling asleep or wakes frequently?	☐ NO	☐ YES
Are you on a private well water or reverse osmosis filter?	☐ NO	☐ YES			