Health History Form
6 and Up

Date: ________________________ **Name:** _______________________________ **DOB:** _______________________

Pharmacy: ____

Please **CIRCLE** One

Primary Language in home: English | Spanish | Other: ___________________________

Ethnicity: Not Hispanic or Latino | Hispanic or Latino

Race: White | Asian | Native Hawaiian / Pacific Islander | Black / African American | 2 or more races

Current Medications: ____

Allergies: ____

Patient's Past Medical History	CIRCLE One		Additional Information (ex: Test / Date / Details)
Prior Testing/Development Test	None	Yes	Test:
Allergies	No	Yes	
History of Chicken Pox	No	Yes	Date:
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU/Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Skin Disease	No	Yes	
History of Injury/Trauma	No	Yes	Details:
Other Medical History	No	Yes	

Family Health History	CIRCLE One		Please List Family Member & details below
Bleeding disorder	No	Yes	
Cancer	No	Yes	
Diabetes	No	Yes	
Cardiovascular disorder	No	Yes	
Congential heart disease	No	Yes	
Eye disorder	No	Yes	
Ear disorder	No	Yes	
Respiratory disorder	No	Yes	
GI disorder	No	Yes	
Musculoskeletal disorders	No	Yes	
Neurologic disorder	No	Yes	
Psychiatric disorder	No	Yes	
SIDS	No	Yes	
Skin disease	No	Yes	
Other Medical History	No	Yes	

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Patient Smoking Status (13 years & over) | **CIRCLE** One

1	Current everyday smoker	4	Never smoker
2	Current someday smoker	5	Smoker, current status unknown
3	Former smoker	6	Unknown if ever smoked

Patient's Surgical / Hospitalization History	**CIRCLE** One		**Details**
Non-Surgical hospitalizations	None	Yes	
Surgical History	None	Yes	
Ear Surgery	None	Yes	
Nose/Mouth/Throat Surgery	None	Yes	
Respiratory Surgery	None	Yes	
Cardiovascular Surgery	None	Yes	
GI Surgery	None	Yes	
GU Surgery	None	Yes	
Eye Surgery	None	Yes	
Orthopedic Surgery	None	Yes	
Plastic Surgery	None	Yes	
Other Surgery	None	Yes	

Child Social History

CIRCLE all that apply

Parent Information:

Parents together	Father involved	Guardian parents
Lives w/Mother	Mother not involved	Same sex partners
Lives w/Father	Mother involved	Other: ________________________
Father not involved	Mother / Father deceased	

Home occupants: (list **ALL**) ____

Parents smokers: (**CIRCLE** One) Yes No Outside Only

Pets:

None	**How many Inside (#)**	**How many Outside (#)**
Dog(s)		
Cat(s)		
Bird(s)		
Reptile(s)		
Rodent(s)		
Fish(s)		
Other: __________________		

Health History Form
6 and Up

Patient's Educational / School Information

Name of School: ____

Grade: ______________________________

School Performance: **CIRCLE** all that apply

Likes School	Dislikes School	Advanced Program	Honor Roll
Excellent	Good	Fair	Poor

School Issues: **CIRCLE** all that apply

None	Behavior Problems	Peer Problems	Non Attendance
Expelled	Suspended	Referred for ADHD testing by school	

Menstrual History (female only)

Approximate LMP: ______________________ Menarche* Age: ______________________

Cycle Length: ______________________ Amount of flow: ______________________

*first menstrual cycle / first menstrual bleeding