CHILDREN'S MEDICAL HISTORY
O-10 YEARS OLD

Date: _____ Patient #_____

Allergies: medications_____ Other:_____

Name:_____ Sex:_____
Age:_____ Birth Date:_____ Referred by:_____
Parent or guardian's name(s):_____
Address:_____ City: _____ ST: _____ ZIP: _____
Home phone:_____ Work phone:_____ Message phone:_____
Other emergency contact:_____

MOM'S HISTORY

#Of Pregnancies:_____ #Of Live Births:_____#Of Living Children:_____
Medications taken during pregnancy_____
This child's sibling order:_____ Time interval since preceding pregnancy:_____
Mother's problems during pregnancy, labor, delivery or other: _____
_____
This child carried to full term? _____yes _____no If no, delivered at how many weeks? _____
Mother's age this pregnancy:_____

FAMILY HISTORY (list who and include parents, grandparents, and siblings)

High blood pressure:_____ Heart disease:_____
Stroke:_____ Cancer:_____
Diabetes:_____ Birth deformities:_____
Tuberculosis:_____ Other:_____

CHILDHOOD HISTORY

Weight at birth:_____ Length at birth:_____
Newborn problems (jaundice, feeding):_____ Congenital defects _____
Feeding, diet problems, bowel
movements:_____
_____
Hospitalization/Surgeries/Serious illnesses:_____
_____
Frequent infections of ear, throat, bladder, other:_____

Currently taking any medications for any chronic condition?_____

If yes explain:_____

Non-prescription Medications:_____

Skin problems:_____ Other:_____

DEVELOPMENT (Please list at what age your child did the following):

Sat-up:_____ Walked:_____ Toilet trained:_____

1st Words:_____ Sentences:_____

Comments:_____

I GIVE MY CONSENT FOR CARE OF THE ABOVE NAMED INDIVIDUAL AT BLUE MOUNTAIN CLINIC.

_____

Signature of parent or guardian Date