PAST MEDICAL HISTORY

1. Who lives in the house with the children listed below? _____
2. Are there smokers in the home? ☐ No ☐ Yes If yes, please circle: Inside Outside Car
3. Are there guns in the home? ☐ No ☐ Yes If yes, are they locked? ☐ No ☐ Yes

Child 1	Child 2	Child 3
Full Name: _____	**Full Name:** _____	**Full Name:** _____
☐ ADD/ADHD	☐ ADD/ADHD	☐ ADD/ADHD
☐ Abdominal Pain/GER	☐ Abdominal Pain/GER	☐ Abdominal Pain/GER
☐ Allergies	☐ Allergies	☐ Allergies
☐ Anemia or bleeding problem	☐ Anemia or bleeding problem	☐ Anemia or bleeding problem
☐ Anxiety	☐ Anxiety	☐ Anxiety
☐ Asthma	☐ Asthma	☐ Asthma
☐ Autism	☐ Autism	☐ Autism
☐ Bed-wetting (after 5yrs old)	☐ Bed-wetting (after 5yrs old)	☐ Bed-wetting (after 5yrs old)
☐ Bladder or kidney infections	☐ Bladder or kidney infections	☐ Bladder or kidney infections
☐ Blood Transfusion	☐ Blood Transfusion	☐ Blood Transfusion
☐ Cancer	☐ Cancer	☐ Cancer
☐ Concussion	☐ Concussion	☐ Concussion
☐ Constipation	☐ Constipation	☐ Constipation
☐ Chronic skin problems	☐ Chronic skin problems	☐ Chronic skin problems
☐ Developmental Delays	☐ Developmental Delays	☐ Developmental Delays
☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Eating Disorder	☐ Eating Disorder	☐ Eating Disorder
☐ Eye conditions	☐ Eye conditions	☐ Eye conditions
☐ Frequent ear infections	☐ Frequent ear infections	☐ Frequent ear infections
☐ Frequent headaches	☐ Frequent headaches	☐ Frequent headaches
☐ Hearing Impairment	☐ Hearing Impairment	☐ Hearing Impairment
☐ Heart problems/Heart murmur	☐ Heart problems/Heart murmur	☐ Heart problems/Heart murmur
☐ Kidney/Urologic Disease	☐ Kidney/Urologic Disease	☐ Kidney/Urologic Disease
☐ Metabolic/Genetic Disorder	☐ Metabolic/Genetic Disorder	☐ Metabolic/Genetic Disorder
☐ Orthopedic problems	☐ Orthopedic problems	☐ Orthopedic problems
☐ Pneumonia	☐ Pneumonia	☐ Pneumonia
☐ Recurrent UTI's	☐ Recurrent UTI's	☐ Recurrent UTI's
☐ Serious injuries or accidents	☐ Serious injuries or accidents	☐ Serious injuries or accidents
☐ Seizures	☐ Seizures	☐ Seizures
☐ Thyroid problems	☐ Thyroid problems	☐ Thyroid problems
☐ Use of alcohol or drugs	☐ Use of alcohol or drugs	☐ Use of alcohol or drugs
☐ Visual Impairment	☐ Visual Impairment	☐ Visual Impairment
Other:	Other:	Other:
_____	_____	_____
Surgeries/Dates: ☐ None	Surgeries/Dates: ☐ None	Surgeries/Dates: ☐ None
_____	_____	_____
Hospitalizations/Date: ☐ None	Hospitalizations/Date: ☐ None	Hospitalizations/Date: ☐ None
_____	_____	_____
Food/Medication Allergies: ☐ None	Food/Medication Allergies: ☐ None	Food/Medication Allergies: ☐ None
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

1. Who lives in the house with the children listed below? _____
2. Are there smokers in the home? ☐ No ☐ Yes If yes, please circle: Inside Outside Car
3. Are there guns in the home? ☐ No ☐ Yes If yes, are they locked? ☐ No ☐ Yes

Child 4
Full Name: _____

- ☐ ADD/ADHD
- ☐ Abdominal Pain/GER
- ☐ Allergies
- ☐ Anemia or bleeding problem
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Bed-wetting (after 5yrs old)
- ☐ Bladder or kidney infections
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Concussion
- ☐ Constipation
- ☐ Chronic skin problems
- ☐ Developmental Delays
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eye conditions
- ☐ Frequent ear infections
- ☐ Frequent headaches
- ☐ Hearing Impairment
- ☐ Heart problems/Heart murmur
- ☐ Kidney/Urologic Disease
- ☐ Metabolic/Genetic Disorder
- ☐ Orthopedic problems
- ☐ Pneumonia
- ☐ Recurrent UTI's
- ☐ Serious injuries or accidents
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Use of alcohol or drugs
- ☐ Visual Impairment

Other:
_____
Surgeries/Dates: ☐ None
_____
Hospitalizations/Date: ☐ None
_____
Food/Medication Allergies: ☐ None
_____
_____

Child 5
Full Name: _____

- ☐ ADD/ADHD
- ☐ Abdominal Pain/GER
- ☐ Allergies
- ☐ Anemia or bleeding problem
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Bed-wetting (after 5yrs old)
- ☐ Bladder or kidney infections
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Concussion
- ☐ Constipation
- ☐ Chronic skin problems
- ☐ Developmental Delays
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eye conditions
- ☐ Frequent ear infections
- ☐ Frequent headaches
- ☐ Hearing Impairment
- ☐ Heart problems/Heart murmur
- ☐ Kidney/Urologic Disease
- ☐ Metabolic/Genetic Disorder
- ☐ Orthopedic problems
- ☐ Pneumonia
- ☐ Recurrent UTI's
- ☐ Serious injuries or accidents
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Use of alcohol or drugs
- ☐ Visual Impairment

Other:
_____
Surgeries/Dates: ☐ None
_____
Hospitalizations/Date: ☐ None
_____
Food/Medication Allergies: ☐ None
_____
_____

Child 6
Full Name: _____

- ☐ ADD/ADHD
- ☐ Abdominal Pain/GER
- ☐ Allergies
- ☐ Anemia or bleeding problem
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Bed-wetting (after 5yrs old)
- ☐ Bladder or kidney infections
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Concussion
- ☐ Constipation
- ☐ Chronic skin problems
- ☐ Developmental Delays
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eye conditions
- ☐ Frequent ear infections
- ☐ Frequent headaches
- ☐ Hearing Impairment
- ☐ Heart problems/Heart murmur
- ☐ Kidney/Urologic Disease
- ☐ Metabolic/Genetic Disorder
- ☐ Orthopedic problems
- ☐ Pneumonia
- ☐ Recurrent UTI's
- ☐ Serious injuries or accidents
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Use of alcohol or drugs
- ☐ Visual Impairment

Other:
_____
Surgeries/Dates: ☐ None
_____
Hospitalizations/Date: ☐ None
_____
Food/Medication Allergies: ☐ None
_____
_____