

**PAST MEDICAL HISTORY**

Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_ Chart No. \_\_\_\_\_ Sex M F

Email Address \_\_\_\_\_ Race \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

**ALLERGIES/MEDICATIONS**

Is your child allergic to any medications? Yes No

Name of medication(s) and type(s) of reaction \_\_\_\_\_  
\_\_\_\_\_

Is your child on any medication(s) or herbal supplement(s) at this time or recently?

Name of medication(s) or herbal supplement(s) \_\_\_\_\_  
\_\_\_\_\_

Does your child have any environmental or food allergies? Yes No

Please list allergen and type of reaction \_\_\_\_\_  
\_\_\_\_\_

**RECENT PAST MEDICAL HISTORY  
(within the last year)**

Has your child been ill since your last visit? If so explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child experienced any trauma, accidents or surgeries since seen in the office last? If so explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child been hospitalized since seen in the office last? If so explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any significant medical changes in your family's medical history? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_