

# CHILD MEDICAL HISTORY FORM

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Dear Parent(s),

Please send this back to our office as soon as you have completed it along with the "Information for Patients" and "Office Policy" forms and a photograph of your child.

Date \_\_\_\_\_ Name of Patient \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Phone Home \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

Name of Parent(s) \_\_\_\_\_

Parent(s)' Address/Phone if different from above \_\_\_\_\_

\_\_\_\_\_

In case of emergency, notify \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Insurance company and policy # (only if we are covered) \_\_\_\_\_

\_\_\_\_\_

Chief health concerns:

Unusual circumstances of pregnancy or birth:

Childhood illnesses (including accidents, surgeries, hospitalizations):

Immunization history (include any complications):

Name, address, and phone number of current pediatrician:

Family medical history:

Dietary or nursing problems:

Current medications and nutritional supplements (write on separate page if necessary):

Significant traumas in your child's life :

Current stresses in your child's life:

What is most unusual about your child?

Any other concerns or information that you would like to share?