<u>**Current Patient Check Up Form (ages 3yr and up)**</u>

Date ______________________________

Name ____D.O.B. _______________________________

Current problems/Concerns ____

Allergies (Medications, Vaccines, Food, others)____

Current Medications ____

CHILD'S PAST MEDICAL HISTORY

Since your child's last check up, has she or he had:

	Yes	No
Hospitalizations?	☐	☐
Surgeries?	☐	☐
Emergency room or urgent care visits?	☐	☐

If yes to any of the above questions, please explain?

____

Does your child see the eye doctor regularly?	☐	☐
Does your child visit the dentist regularly?	☐	☐

Has your child ever been treated for any of the following?

	Yes	**No**
ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart Murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear Infections	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problem?____

Has your child ever been seen by a specialist? ________________ If so, please describe?

____

Has your child ever had:	**Yes**	**No**
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in chest during exercise?	☐	☐

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs. old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

Who lives in your child's home? ____

If parents are not living together or if child does not live with parents, what is the child's custody status?

____

Is your child in: Daycare? _________________ School? __________________ If so, what grade? _____________

Do you have any concerns about your child's school performance? ______________________________________

____

Any changes to your home life? (death, divorce, social stress?) ____

Do you have any special concerns today? ____