BIG HORN
EAR, NOSE & THROAT
Hometown Care for Your Family

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CHILD MEDICAL HISTORY FORM

Date: _____ Preferred Pharmacy: _____

Name: _____ Age: _____

Referring Physician's name or Primary Care Physician and address, if known:

_____

_____

Briefly state why your child is being seen today **(Chief Complaint)**

_____

_____

Review of Symptoms:
Check all symptoms that your child is **currently** or has **recently** experienced:

__Unexplained Weight Loss
__Change in Vision
__Shortness of Breath/Wheezing
__Problems with Speech
__Bleeding/Bruising Easily
__Diarrhea
__Fevers/Night Sweats
__Heat/Cold Intolerance
__Developmental Delays
__Muscle or Joint Pain
__Problems with Urination
__Constipation
__Other: _____

_____

Is there anything else we should know about your child's health that is not covered by these questions? YES NO

If yes, please explain:

Past History:
Check (√) any current or past **medical problems:**

__Attention Deficit Disorder
__Mental Retardation
__Hearing Loss
__Gastroesophageal Reflux
__Hepatitis/Liver Disease
__Thyroid Disease
__Tuberculosis
__Heart Trouble or Murmur
__Cystic Fibrosis
__Seizures
__Ear Infections
__Frequent Spitting Up
__Bleeding Disorders
__Tumor/Cancer
__Nasal Allergies
__Prematurity (born more than 4 weeks early)
__Cerebral Palsy
__Depression
__Strep Throat
__Kidney Problems
__Asthma/Lung Disease
__Anemia
__Other:_____

_____

---OVER---

Is your child **allergic** to any medications? YES NO

If yes, please list the medication(s) and the reaction (rash, difficulty breathing, etc.): _____
_____
_____

List all current **medications** including vitamins and herbal supplements:

Medication Name	Dose	Reason for Taking

List all previous **operations**, including year performed:
_____
_____

Family History:
Circle any of the following diseases that run in your family and who has them:

Diabetes	Child's Mother	Child's Father	Child's Siblings
Heart Disease	Child's Mother	Child's Father	Child's Siblings
High Blood Pressure	Child's Mother	Child's Father	Child's Siblings
Early Hearing Loss	Child's Mother	Child's Father	Child's Siblings
Cancer	Child's Mother	Child's Father	Child's Siblings

Social History:

Does the child or anyone smoke at the home?	YES	NO
Any possibility the child is pregnant?	YES	NO
Was the child breastfed as an infant?	YES	NO

With whom does the child live? (parents, grandparents, legal guardian)_____
Who is the child's legal guardian? _____

<u>Nurse Use Only</u>
Vital Signs

Height: _____
Weight: _____
B.P.: _____
Temp: _____
Pulse: _____
Resp: _____ Surgery Date_____
SpO2 _____