# Patient Health History

Today's Date:_____

Patient's Name:_____ Date of Birth (DOB):_____
Parent:_____ Occupation:_____
Parent:_____ Occupation:_____
Parents: (Circle One) Married Unmarried Divorced Separated Domestic Partner
Other Caregivers: _____ Relation:_____

## ***Patient's Current Health***

Is your child taking prescription or over the counter medications, vitamins or supplements? _____Yes _____No
Name and dosing of medications:_____
Any allergies to medications?_____Yes_____No Please list:_____
Your child's Dentist::_____
Other Healthcare Providers_____

## ***Patient's Health History***

Pregnancy Complications:_____
Birth Complications:_____
Hospitalizations:_____Yes No
Illness:_____Date:_____
Surgeries:_____Yes No
Procedures:_____Date:_____
Injuries/Fractures:_____Yes No
Hearing Problems:_____Yes No
Vision Problems:_____Yes No
Ear/Nose/Throat Problems:_____Yes No
Asthma:_____Yes No

Allergies or Hayfever:_____Yes No
Cardiac Conditions:_____Yes No
Diabetes/Thyroid Problems:_____Yes No
Kidney Problems:_____Yes No
Gastro/Intestinal Problems:_____Yes No
Migraines or Headaches:_____Yes No
Anemia/Low Iron:_____Yes No
Scoliosis:_____Yes No
ADHD/ADD:_____Yes No
Learning Disability:_____Yes No
Autism/Developmental Delay:_____Yes No

## ***Family Health History***

Have any biological family members **(mother (M), father (P), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF) or brothers and sisters)** had any of the following **(state whom)**:

Parental Height: Mother_____ Father_____
Hearing Loss before age 50:_____
Vision Impairment:_____
Asthma:_____
Allergies or Hayfever:_____
Eczema:_____
Heart Disease before age 50:_____
High Blood Pressure:_____
High Cholesterol:_____
Diabetes:_____
Thyroid Disorder:_____
Kidney Disease:_____
Epilepsy (Seizures):_____
Migraines:_____

Breast or Ovarian Cancer:_____
Colon Cancer:_____
Other Cancer (list type)::_____
Bleeding Disorder/Blood Clots:_____
Alcohol or Substance Abuse:_____
Depression:_____
Anxiety/OCD:_____
Other Mental Illness:_____
ADHD/ADD:_____
Learning Disability:_____
Autism or Developmental Delay:_____
Scoliosis: _____
Other: _____