



CHILDREN'S MEDICAL HISTORY
O-10 YEARS OLD

Date: _____ Patient # _____

Allergies: medications _____

Other: _____

Name: _____ Sex: _____

Age: _____ Birth Date: _____ Referred by: _____

Parent or guardian's name(s): _____

Address: _____ City: _____ ST: _____ ZIP: _____

Home phone: _____ Work phone: _____ Message phone: _____

Other emergency contact: _____

MOM'S HISTORY

#Of Pregnancies: _____ #Of Live Births: _____ #Of Living Children: _____

Medications taken during pregnancy _____

This child's sibling order: _____ Time interval since preceding pregnancy: _____

Mother's problems during pregnancy, labor, delivery or other: _____

This child carried to full term? _____ yes _____ no If no, delivered at how many weeks? _____

Mother's age this pregnancy: _____

FAMILY HISTORY (list who and include parents, grandparents, and siblings)

High blood pressure: _____ Heart disease: _____

Stroke: _____ Cancer: _____

Diabetes: _____ Birth deformities: _____

Tuberculosis: _____ Other: _____

CHILDHOOD HISTORY

Weight at birth: _____ Length at birth: _____

Newborn problems (jaundice, feeding): _____ Congenital defects _____

Feeding, diet problems, bowel movements: _____

Hospitalization/Surgeries/Serious illnesses: _____

Frequent infections of ear, throat, bladder, other: _____

Currently taking any medications for any chronic condition? _____

If yes explain: _____

Non-prescription Medications: _____

Skin problems: _____ Other: _____

DEVELOPMENT (Please list at what age your child did the following):

Sat-up: _____ Walked: _____ Toilet trained: _____

1st Words: _____ Sentences: _____

Comments: _____

I GIVE MY CONSENT FOR CARE OF THE ABOVE NAMED INDIVIDUAL AT BLUE MOUNTAIN CLINIC.

Signature of parent or guardian

Date