Child Medical Summary Patient Name: _____ Date of Birth_____

Past Medical History: (Please check all that apply) **Today's date:** _____

◯ Anxiety Disorder	◯ Fibromyalgia	◯ Migraine Headaches
◯ Arthritis	◯ Gout	◯ MRSA Infections
◯ Asthma	◯ Has pacemaker	◯ Mumps
◯ Bleeding Disorder	◯ Heart Attack	◯ Osteoporosis
◯ Cancer	◯ Hepatitis	◯ Pneumonia
◯ Chicken Pox	◯ Hive or Eczema	◯ Seizure Disorder
◯ Depression	◯ Kidney Disease	◯ Scarlet Fever
◯ Diabetes- Insulin	◯ Kidney Stones	◯ Stroke
◯ Diabetes Non-Insulin	◯ Learning Disabilities	◯ Whooping Cough
◯ Difficulty in Urinating	◯ Liver Disease	◯ Other, Explain_____
◯ Diverticulitis	◯ Measles	_____

Drug Allergies: _____

Past Surgical / Hospital History:

Surgery/Hospitalizations	Reason	Year	Hospital
1.			
2.			
3.			
4.			
5.			

Family Health History:

Relation (please check across all that apply or indicate type)	**Alive y/n**	**Age**	**Alcoholism**	**Anemia**	**Cancer/ type**	**Diabetes**	**Heart Disease**	**Hypertension**	**Kidney Disease**	**Liver Disease**	**Mental Disorder / type**	**stroke**	**Thyroid Disorder**
Grandmother (maternal)													
Grandfather (maternal)													
Grandmother (paternal)													
Grandfather (paternal)													
Father													
Mother													
Brother/Sister 1.													
2.													
3.													
4.													

Social Information:

	Yes/No	**Details (how many, where, who)**
Exercise		
Live with		
Personal Safety		
1. Have you been hit, punched, strangled or threatened to hurt you?		
2. Do you wear a seat belt?		
Do you wear or need glasses or contacts?		
Do you wear or need a hearing aid?		
Do you use a cane, walker or wheelchair?		
Weight at Birth		
Pregnancy or Birth Complications:		
Locations patient has gone for immunizations:		