CHOC Children's Specialists

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HEALTH HISTORY RECORD *Please answer each question (to be completed by parent or guardian)*

Patient's Name:_____Age:_____Date of Birth:_____Sex:_____
Father's Name: _____ Occupation: _____ Marital Status: _____
Mother's Name:_____ Occupation: _____ Marital Status: _____
What is the reason for today's visit? _____
What is your relationship to the child/patient? _____ Other siblings treated in our office?_____
Who referred you to our office?_____Who is the child's pediatrician?_____
*Has your child traveled outside of the country in the past 3 weeks? _____
*Do you or your child currently have a cough? _____
Is your child currently in any pain? _____ If yes, where is the pain located?_____
Are your child's immunizations up to date? _____ If no, please explain:_____
Does your child have any allergies to medication? _____ If yes, please list:_____
Please list any prescription and non-prescription medication your child is currently taking:
_____
Please list any chronic medical problems your child is being treated for:
_____
Please list any surgical procedures your child has undergone (including approximate dates):
_____
Does anyone smoke in the household? _____ Are there pets in the household?_____
Please list all members of the household (include age):_____
Was/is your child breast-fed or bottle-fed? _____Is your child in daycare or preschool?_____

Family Medical History: *Please check yes or no if any relatives have or had any of the following illnesses:*

	Yes	No	Family member(s) relation to patient
Ear or Hearing problem	☐	☐	_____
Asthma	☐	☐	_____
Bleeding disorder	☐	☐	_____
Problems with anesthesia	☐	☐	_____

Any other illness not listed above?_____

What is the name and address of your preferred pharmacy? _____

Child's birth weight?_____ Any problems during pregnancy?_____
Born premature?_____ If so, how many weeks? _____ NICU Stay?_____
Has your child ever been intubated?_____ For how long?_____

System review: Does your child have or <u>EVER HAD</u> any of the following (check all that apply):

☐ Recurrent ear infections	☐ Bedwetting	☐ Muscle weakness
☐ Hearing Loss	☐ Mouth breathing	☐ Failure to thrive
☐ Dizziness/Imbalance	☐ Swollen lymph nodes/glands	☐ Kidney Liver problems
☐ Speech problems	☐ Swallowing problems	☐ Bleeding disorder
☐ Runny nose	☐ Headache/Sinus pain	☐ Vision/Eye problems
☐ Sneezing	☐ Asthma/Lung problems	☐ Behavior problems
☐ Stuffy nose	☐ Cystic Fibrosis	☐ Seizures
☐ Itchy/watery eyes	☐ Recurrent pneumonia	☐ Blood transfusion
☐ Recurrent Sinusitis	☐ Stomach acid reflux	☐ Anemia
☐ Nose bleeds	☐ Spitting up/vomiting	☐ Skin condition/rashes
☐ Bad breath	☐ Intestinal problems	☐ Broken bones
☐ Loud snoring	☐ Immune Deficiency	☐ Other:_____
☐ Recurrent sore throat/Tonsillitis	☐ Unknown cause/recurrent fever	☐ All others negative

I confirm that the above is true and correct to the best of my knowledge (Parents/Guardians please sign)

Print Name: _____Signature: _____Date: _____

Office use only: Reviewed by: _____Date: _____

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