Medical History

Childhood Health Associates of Salem

Child's Name:_____ **Date of Birth:**_____
Last First Middle Month Day Year

1. Is your child allergic to any drugs or medicines? ☐ Yes ☐ No Which ones?_____
2. Any problems during the pregnancy or delivery for this child? ☐ Yes ☐ No Describe:_____
3. Was this child born early? ☐ Yes ☐ No How early?_____ Birth weight:_____
4. Was your child born or immunized outside of the USA? ☐ Yes ☐ No Where?_____
5. Has your child ever had surgery? ☐ Yes ☐ No What for?_____
6. Has your child ever been hospitalized overnight? ☐ Yes ☐ No What for?_____
7. Has your child ever had any chronic disease? ☐ Yes ☐ No Describe:_____
8. Has your child ever had any serious injury? ☐ Yes ☐ No Describe:_____
9. Has your child been receiving any medicine or treatment for longer than 1 month? ☐ Yes ☐ No
   Describe: _____
10. **Has your child ever had...**

☐ ADHD / ADD	☐ Allergies / "hay fever"	☐ Asthma	☐ Behavior problems	☐ Birth defects
☐ Bladder or kidney problem	☐ Bone or muscle problem	☐ Broken bone (fracture)	☐ Cancer	☐ Chickenpox
☐ Eczema	☐ Hearing problem	☐ Heart problem	☐ Hepatitis	☐ Learning disability or problem
☐ Meningitis	☐ Pneumonia	☐ Seizures / Epilepsy	☐ TB disease or exposure	☐ Vision problems

Please tell us more about anything circled above: _____

_____

11. Is there any family history of..

☐ ADHD / ADD	☐ Allergies / "hay fever"	☐ Arthritis	☐ Asthma	☐ Behavior problems
☐ Birth defects	☐ Bladder or kidney problem	☐ Bone or muscle problem	☐ Broken bone / fracture	☐ Cancer
☐ Chickenpox	☐ Diabetes	☐ Eczema	☐ Hearing problem	☐ Heart disease or problem
☐ High blood pressure	☐ Hepatitis	☐ Learning disability or problem	☐ Meningitis	☐ Obesity
☐ Pneumonia	☐ Seizures / Epilepsy	☐ Smoking	☐ TB disease or exposure	☐ Vision problems

Please tell us more about anything circled above: _____

_____

12. Anything else you would like to share about your child's health: _____

_____

Signed: _____ **Date**: _____

Name of person filling out form: _____ Relationship to patient: _____