Kids Way Clinic
Patient History
Please take a moment to update your child's medical history.
DO NOT LEAVE ANYTHING BLANK.

Child's Name: _____ DOB: _____
Who is filling this form out? _____
Does your child have any medication allergies? _____
Are there any smokers in the home? _____
Last Dental Exam? _____ Name of Dentist? _____
Last Vision Exam? _____ Name of Eye Doctor? _____

Current and Past History:

	YES	NO	Please explain, include medication names and dates
Is your child currently on any medications?			
Does your child have any serious or chronic illnesses?			
Has your child had serious injuries or accidents?			
Has your child had any surgeries?			
Has your child ever been hospitalized?			
Has your child ever had a reaction to any immunization?			

Please give details regarding your ***child's*** medical history:

	YES	NO	Please explain, include dates	Treated by
Asthma, recurrent cough, bronchitis, or pneumonia				
Nasal allergies or eczema				
Frequent ear infections or sore throat				
Problems with ears or hearing				
Problems with eyes, vision, or teeth				
Frequent headaches or other neurologic problems				
Frequent abdominal pain				
Constipation requiring doctor visits				

	YES	NO	Please explain, include dates	Treated by
Bladder/Kidney problems or bedwetting				
Any heart problems/murmur				
Anemia or bleeding problems				
Thyroid or other gland problem				
Diabetes				
ADD/ADHD				
Mental Health Issues				
Use of drugs or alcohol				
Other				

Have any ***family members*** had the following?

	YES	NO	Explain	Who? Mom,dad,aunt, uncle, grandparents? Moms side or Dads side?		YES	NO	Explain	Who? Mom,dad,aunt, uncle, grandparents? Moms side or Dads side?
Alcohol/Drug Abuse					Immune Disorders				
Asthma or Allergies					Joint Problems				
Birth Defects					Kidney Disease				
Blood Disorders					Liver Disease				
Bone Disorders					Lung Disease				
Cancer					Migraine Headaches				
Endocrine Disease, Thyroid Problems or Diabetes					Metabolic Disorders				
Ear/Nose/Throat Disorders					Obesity				
Eye Disorders					Seizure Disorder				
Heart Disease					Stroke History				
High Blood Pressure					Mental Health Disorders				
High Cholesterol					Other Medical Problems				