Patient Label

Our Kids®

Medical History Form

Please fill out form on front and back.

Patient Name:_____Date of Birth:_____
Parent's Names:_____
Name of person filling out form (if other than parent):_____
Your relationship to child:_____
Sibling Names & Ages:_____

Birth & Development:
- Full term? □ Yes □ No
- Birth Weight _____
- Delivery □ Vaginal □ C-section
- Birth complications_____
- Pregnancy issues (meds, STDs, abnormal Pap)

_____

Past Medical History:
- Chronic Illnesses:_____
- Hospitalizations:_____
- Surgeries:_____
- Broken bones, burns or stitches:

_____

Allergies: □ None
□ Medications_____
□ Food/Environmental_____
□ Latex

Medications (taking any?) □ Yes □ No
- If yes, what?_____

_____
_____

Immunizations Up-to-Date? □ Yes □ No

Primary Care Provider Name & Address:_____

Social History:
- Daycare: □ Yes □ No
- School □ Yes □ No

If yes, grade level_____
Name of school:_____
Held back □ Yes □ No
Special Ed □ Yes □ No

- Developmental delays_____
- Behavior problems:_____

Has your child had any examinations of his/her genital area or anal area? ..... □ Yes □ No
If yes, when and where?_____

Has your child ever injured or hurt his/her genital or anal area? ..... □ Yes □ No
If yes, what happened and when?_____

PATIENT HISTORY

Check box if your child has or has had any of the following conditions:

Anemia..... ....□	Heart murmur.....□
Autism..... .....□	High cholesterol ..... □
ADHD..... .....□	High blood pressure ..... □
Asthma..... .....□	Kidney disease.....□
Bedwetting ....□	Painful urination.....□
Birth defects ....□	Seizures ..... □
Bleeding disorders..... ....□	Skin disorders ..... □
Blood in urine or stool.....□	Stomachaches ..... □
Blood in genital area.....□	Teeth problems.....□
Blood in underwear.....□	Throat infections.....□
Bowel movements in pants.□	Urinating in pants.....□
Cancer..... .....□	Urinary catheterization....□
Chronic diarrhea..... .....□	Urinary tract infections....□
Constipation..... .....□	Past sexual abuse ..... .□
Headaches..... .....□	
Heart disease ....□	

Explain positive answers, if needed:

Family history: Cancer □ Yes □ No Diabetes □ Yes □ No Heart problems □ Yes □

Over 12 years of age, is your child sexually active? □ Yes □ No
Is your child using any form of birth control? □ Yes □ No

For girls only... .....

- Has she started her periods? □ Yes □ No
  If yes, age she started? _____
  Date of last period?_____
  Does she use tampons? □ Yes □ No
- Previous PAP smear or speculum exam? □ Yes □ No

For girls over age 9, has she received the cervical cancer vaccine yet? □ Yes □ No