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CONFIDENTIAL PATIENT HEALTH PROFILE

Patient Name:_____ Age:_____ Sex:_____ Date of Birth: _____

_____ _____

Name of person completing form Relationship to patient

PAST MEDICAL HISTORY

(PLEASE CHECK MEDICAL PROBLEMS THAT YOUR CHILD HAS HAD IN THE PAST)

___BLADDER INFECTION
___KIDNEY INFECTIONS
___RHEUMATIC FEVER
___HEART TROUBLE
___ULCERS
___PNEUMONIA
___ASTHMA
___SEIZURES/STROKES
___GLASSES/CONTACT LENS
___DIARRHEA
___DIABETES
___EAR INFECTIONS
___SINUSITIS
___TONSILLITIS
___HEADACHES
___HERPES
___HEARING LOSS
___CONSTIPATION
___CHICKEN POX (Age/Yr: _____)
___MEASLES
___MUMPS
___T.B.
___POLIO
___SICKLE CELL
___SMOKING
___HIGH BLOOD PRESSURE
___AGE AT MENSTRATION (if applicable)

___FRACTURES: Provide child's age and location of break(s): _____

_____

_____

LIST ALL SURGERIES: (Please indicate child's age at time of surgery)

_____

_____

OTHER MEDICAL PROBLEMS:_____

_____

_____

DEVELOPMENT & GROWTH: WNL Y / N If no, please explain:_____

_____

MENTAL HEALTH STATUS: Normal for age Y / N If no, explain:_____

_____

RELAVENT FAMILY HISTORY:_____

_____

ALLERGIES TO MEDICINES: YES NO (LIST IF APPLICABLE)

_____

ALLERGIES TO OTHER: YES NO (LIST IF APPLICABLE)

_____

MEDICATIONS

Previously taken:_____

Currently taking:_____

_____

Parent/Guardian Signature

_____

Reviewed by: Name & Title