F.W. HUSTON MEDICAL CLINIC

(For **Pediatric patients** ≤ 10 years old)

Name: _____ Date of Birth: _____ Age: _____

Reason for visit / current concerns**:** _____

Child's Primary Physician/Provider: _____

Is the child yours by: ❑ Birth ❑ Adoption ❑ Stepchild ❑ Other relation: _____

Birth: ❑ Full term ❑ Premature, born at ____ weeks. Problems during pregnancy or delivery? ❑ Yes ❑ No

Birth weight: _____ Birth length: _____ Problems during newborn period? ❑ Yes ❑ No

Current Medications or Vitamins: ❑ None

_____
_____
_____
_____

Drug Allergies (list reaction): ❑ None

_____
_____
_____
_____

Surgeries / Hospitalizations: _____ ❑ None

Current or Chronic Medical Problems: ❑ None

Has your child ever been diagnosed or treated for any of the following?

❑ Anemia
❑ Allergies to: _____
❑ Asthma / wheezing / bronchiolitis
❑ Broken bones: _____
❑ Kidney or bladder infection
❑ Diabetes
❑ Heart murmur
❑ Frequent ear infections
❑ Concussion / head injury
❑ Sleep problems
❑ Seizures
❑ Depression / anxiety
❑ Chickenpox: age _____
❑ Migraine headaches
❑ Learning disability
❑ Hearing problems
❑ Pneumonia
❑ Other: _____

Immunizations:

❑ Up to date ❑ Not up to date ❑ Last Flu shot: _____

Family history:

Have any close relatives (parents, brothers, sisters, etc.) had any of the following?

❑ Allergies / Asthma
❑ Blood or clotting disorders
❑ Depression / psychiatric illness
❑ Cancer, types: _____
❑ Diabetes
❑ Heart disease
❑ Hereditary disease
❑ Other serious illness: _____
❑ High blood pressure
❑ High cholesterol
❑ Stroke

Father: ❑ Living, age: ____ Health problems? _____ ❑ Deceased at age: ___ Cause: _____

Mother: ❑ Living, age: ____ Health problems? _____ ❑ Deceased at age: ___ Cause: _____

Social History:

Child's parents are: ❑ Married ❑ Unmarried ❑ Divorced/Separated ❑ Other: _____

Parents' occupations: Mother _____ Father _____

Who lives in household with the child**?** ❑ Mom ❑ Dad ❑ Siblings (# _____) ❑ Grandparents ❑ Other _____

Childcare: ❑ Parents ❑ Relatives ❑ Daycare/Preschool ❑ Babysitter. Does anyone in the home smoke? ❑Yes ❑ No

Pets in the home? ❑ No ❑ Yes, type: _____ Any guns in the home? ❑ Yes ❑ No

Any concerns about safety, neglect, or abuse in the home? ❑ Yes ❑ No _____

Signature of Responsible Party: _____Today's Date: _____