Medical History

This form is for parents to complete

Patient Name ______________________________ Date of Birth ________________

Person(s) completing this form ____

Why is your child coming to see Dr. Carlton?

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Birth History

Was your child born via vaginal delivery or Cesarean?
(If there were problems, please describe them below) ____________________

Was your child born on time?
(If not, at what week gestation was your child born?) ____________________

Were there any problems during the pregnancy?
(If there were problems, please describe them below) ____________________

Were there any problems during or right after your child's birth?
(If there were problems, please describe them below) ____________________

Please expand on any birth history below:

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Developmental History

Has your child had any …

Problems with gross or fine motor control (now or in the past)?
(If there were problems, please describe them below) ____________________

Learning problems (now or in the past)?
(If there were problems, please describe them below) ____________________

Speech problems (now or in the past)?
(If there were problems, please describe them below) ____________________

Please expand on any developmental history below:

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Medical History
Continued
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Patient Name ____ Date of Birth ______________________________

Immunizations

Are your child's immunizations up to date?
(Please bring your child's immunization card) ____

Has anyone in your household ever had a positive test
for tuberculosis? If so, who? ____

Has your child had chicken pox (the disease)?
If so, at what age? ____

Other Medical Illnesses

Does your child have any chronic medical problems?

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Has your child ever been seen in an emergency room? If so, please list the name of the hospital or ER, the dates of the ER visits and the reason for the visits.

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Has your child ever been admitted to the hospital or had any surgery (in-patient or out-patient)? If so, please list the name of the hospital, the dates and the reason for the admission or surgery.

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Medical History
Continued
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Has your child had any of the following illnesses or problems?

	yes	no	When/Describe
Asthma			
Cancer			
Epilepsy			
Thyroid Disease			
Kidney Problems			
Urinary Problems			
Menstrual Problems			
Stomach Problems			
Constipation			
Migraines			
Chest pain			
Heart Problems			
Weight Loss			
Fainting			
Fatigue			
Broken Bones			
Major Accidents			
Sports Injuries			
Depression			
Psychiatric illnesses			
Drug or Alcohol Use			
Behavioral problems			

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Does your child take any medications? If so, please list them below, including what the medication is treating, the dosage and how frequently it's taken. Please include vitamins and nutritional supplements.

Has your child ever had either for the following tests? If he/she has had the test, please put the date of the test (approximate) and the result.

A DEXA Bone Density Scan: ______________________________

An EKG: ______________________________

Does your child have any allergies to any food or medications? If so, please list the food or medication and the reaction.

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Do you have worries about your child concerning

	yes	no	Describe
Smoking			
Alcohol			
Drugs			
Dating or Sexuality			
Sex			
Birth Control			
Friends			
School			
Physical Activity			
Other Activities			

Is there anything else about your child's medical history that you feel we should know?

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