

Patient Health History (PEDIATRIC)

Last Name:	First Name:			Middle Initial:				
Date of Birth:		_						
Personal/Family Health History:	Please ch	eck all are	eas that a	apply to the patient or their	Mother or	Father.		
Indicate any history of:	Patient	Mother	Father	Indicate any history of:	Patient	Mother	Father	
Depression/Anxiety/ADHD/ Drug use				Headaches/Migraines				
Anemia				Heart defect				
Asthma				Kidney (Renal) Problems/Kidney Stones				
Concussion/Head injury				Seizure/Epilepsy				
Diabetes				Other:				
Eczema								
	1	1	1		<u> </u>		1	
List any past surgical and hospit								
Date Su	Surgery/hospital stay							
Please list below any medication	n (prescript	tion and c	ver the o	counter) and any vitamins th	ne patient	takes:		
Name of medication		Dosage		How many times a	How many times a day			
				l .				
Home Environment: Are there any concerns for weig	ht and/or	school ne	rformano	re? Yes 🗆 No 🗀				
a there any concerns for weig		2311001 PC						
Females Only:								
Ever had a menstrual period? Ye	es 🗌 No	☐ If yes.	age of f	irst menstrual period?				
p			J - 1					
Completed by:				Date:				



Patient Health History (ADULT)

Please list below any medication (prescription and over the counter) and any vitamins that you take Name of medication							
Name of medication							
Personal/Family Health History: Please check all areas that apply to you or your Mother/Father. Indicate any history of: Yourself Mother Father Indicate any history of: Yourself Mother Pather Attack/Heart Failure Alzheimer's Hepatitis/Liver disease Heart High cholesterol High	1						
Indicate any history of: Yourself Mother Father Indicate any history of: Yourself Mother Depression/Anxiety/ ADHD Heart disease/Heart Attack/Heart Failure Attack/Heart Failure Hepatitis/Liver disease Anemia High cholesterol High blood pressure (Hypertension) HIV Asthma/COPD Osteoporosis Kidney (Renal) Problems/Kidney Stones Cancer Seizures/Epilepsy Stones Stomach Reflux/Heartburn Headaches/Migraines Other: Date Surgery/Operation/Hospital	How many times a day						
Indicate any history of: Yourself Mother Father Indicate any history of: Yourself Mother Depression/Anxiety/ ADHD Heart disease/Heart Attack/Heart Failure Attack/Heart Failure Hepatitis/Liver disease Anemia High cholesterol High blood pressure (Hypertension) HIV Asthma/COPD Osteoporosis Kidney (Renal) Problems/Kidney Stones Cancer Seizures/Epilepsy Stones Stomach Reflux/Heartburn Headaches/Migraines Other: Date Surgery/Operation/Hospital							
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Indicate any history of: Yourself Mother Father Indicate any history of: Yourself Mother Depression/Anxiety/ ADHD							
Depression/Anxiety/ ADHD Alzheimer's Alzheimer's Anemia Alzheimer's Anemia Anxiety Anthritis Arthritis Asthma/COPD Blood clots Cancer Correct Cancer Correct Cancer Correct Cancer Correct Cancer Correct Cancer Correct Correc	1						
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Alzheimer's Anemia Anxiety Anxiety Arthritis Arthritis Blood clots Blood clots Cancer Diabetes Stomach Reflux/Heartburn Headaches/Migraines Do you drink alcohol? Yes No Iff you diid drink alcohol in the past, when did you quit?							
Anemia							
Anxiety Arthritis Asthma/COPD Asthma/COPD Blood clots Blood clots Cancer Cancer Diabetes Stomach Reflux/Heartburn Headaches/Migraines List past surgical and hospitalization history: Date Surgery/Operation/Hospital Do you drink alcohol? Yes \ No \ If you did drink alcohol in the past, when did you quit?							
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Arthritis							
Asthma/COPD Blood clots Cancer Cancer Diabetes Stroke Stomach Reflux/Heartburn Headaches/Migraines Cater Date Surgery/Operation/Hospital Do you drink alcohol? Yes \ No \ \ If you did drink alcohol in the past, when did you quit?	+						
Blood clots Kidney (Renal) Problems/Kidney Stones	1						
Blood clots Problems/Kidney Stones Cancer Seizures/Epilepsy Diabetes Stroke Stomach Thyroid disease Headaches/Migraines Other: List past surgical and hospitalization history: Date Surgery/Operation/Hospital Do you drink alcohol? Yes No If you did drink alcohol in the past, when did you quit?	+						
Cancer Seizures/Epilepsy Diabetes Stroke Stomach Reflux/Heartburn Headaches/Migraines Other: List past surgical and hospitalization history: Date Surgery/Operation/Hospital Do you drink alcohol? Yes No Grand you quit?							
Diabetes Stomach Reflux/Heartburn Headaches/Migraines Date Surgery/Operation/Hospital Do you drink alcohol? Yes No grounding you did drink alcohol in the past, when did you quit?							
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Reflux/Heartburn Headaches/Migraines Date Surgery/Operation/Hospital Do you drink alcohol? Yes No If you did drink alcohol in the past, when did you quit?							
Headaches/Migraines List past surgical and hospitalization history: Date Surgery/Operation/Hospital Do you drink alcohol? Yes No lif you did drink alcohol in the past, when did you quit?							
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Do you currently use any street drugs (including marijuana)? Yes 🔲 No 🗌							
If yes, what kind?							
Are there any concerns for weight? Yes \(\square\) No \(\square\)							
Completed by: Date:							