

(PLEASE FILL IN ALL SECTIONS)

Family History (Please check any conditions present in biological mother, father, or siblings)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anesthesia difficulties | <input type="checkbox"/> Kyphosis (Roundback) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pigeon-toed | <input type="checkbox"/> Spondylolisthesis |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Clubfoot | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hip Dysplasia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Legg Perthes | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bowleg | <input type="checkbox"/> Adopted |
| <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Knock Knee | |

Medications YES NO If yes please list with dosages: _____

Allergies Known **drug** allergies? YES NO
Known **food** allergies? YES NO
Known **latex** allergy? YES NO

Please list name of allergic medication/food/substance and the type of reaction (for example: rash, upset stomach, swelling, wheezing, shock or other type reaction): _____

Social History

Parents marital status: (Please circle one) Single Married Separated Divorced Not married Widowed
Child lives with _____ Legal guardian: _____
Number of Brothers _____ Sisters _____
Grade level _____ Employed? Yes No If yes, hours per week: _____
Tobacco use? Yes No Smoking in the home? Yes No
Alcohol use? Yes No Other substance use? Yes No
What sports/exercise do you participate in? _____

Current Medical Status/ ROS (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> good general health | <input type="checkbox"/> wheezing | <input type="checkbox"/> rashes |
| <input type="checkbox"/> recent weight change | <input type="checkbox"/> spitting up blood | <input type="checkbox"/> dry skin/itching |
| <input type="checkbox"/> fever | <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> chronic skin ulcers |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> eye disease/injury | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> glasses/contacts | <input type="checkbox"/> diarrhea | <input type="checkbox"/> blackouts |
| <input type="checkbox"/> blurred/double vision | <input type="checkbox"/> constipation | <input type="checkbox"/> tremors |
| <input type="checkbox"/> hearing loss/ringing | <input type="checkbox"/> indigestion/reflux | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> chronic sinus problem | <input type="checkbox"/> burning/painful urination | <input type="checkbox"/> depression |
| <input type="checkbox"/> nose bleeds | <input type="checkbox"/> frequent urination | <input type="checkbox"/> memory loss or confusion |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> bloody urine | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> joint pain | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> back pain | <input type="checkbox"/> slow to heal after cuts |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> pain at night | <input type="checkbox"/> bruising tendency |
| <input type="checkbox"/> faintness | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> transfusions |
| <input type="checkbox"/> breathing problems | <input type="checkbox"/> muscle weakness | |
| <input type="checkbox"/> chronic/frequent coughs | | |

The above information is correct and accurate to the best of my knowledge. I understand the need to inform the practice of any changes in my medical condition.

Signature _____
(Guardian)

Date _____