

## PATIENT MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

### Birth History If you answer yes, please explain.

Yes No Was the patient born prematurely?  
\_\_\_\_\_

Yes No Were there any complications during the pregnancy?  
\_\_\_\_\_

Yes No Did the patient have any complications following the delivery?  
\_\_\_\_\_

Yes No Was the patient born by Cesarean section?  
\_\_\_\_\_

Birth weight of child: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

### Has the patient ever had any of the following? If yes, please explain.

Yes No Heart murmur  
\_\_\_\_\_

Yes No Chest Pain  
\_\_\_\_\_

Yes No Fainting  
\_\_\_\_\_

Yes No Palpitations/rapid heart beats  
\_\_\_\_\_

Yes No Shortness of breath  
\_\_\_\_\_

Yes No High blood pressure  
\_\_\_\_\_

Yes No Weight Loss  
\_\_\_\_\_

Yes No Fatigue  
\_\_\_\_\_

**PATIENT MEDICAL HISTORY** CONTINUED

Patient's Name: \_\_\_\_\_

Yes      No      Pneumonia  
\_\_\_\_\_

Yes      No      Asthma  
\_\_\_\_\_

Yes      No      Allergies  
\_\_\_\_\_

Yes      No      Digestive/eating problem  
\_\_\_\_\_

Yes      No      Eye disease/eye glasses  
\_\_\_\_\_

Yes      No      Ear/nose/throat problem  
\_\_\_\_\_

Yes      No      Skin problem  
\_\_\_\_\_

Yes      No      Neurologic disorder/ Seizures  
\_\_\_\_\_

Yes      No      ADD/ADHD  
\_\_\_\_\_

Yes      No      Autism Spectrum Disorder  
\_\_\_\_\_

Yes      No      Psychiatric Disorder  
\_\_\_\_\_

Yes      No      Developmental Delays/Learning Disability  
\_\_\_\_\_

Yes      No      Hormone problems/Diabetes  
\_\_\_\_\_

**PATIENT MEDICAL HISTORY** CONTINUED

Patient's Name: \_\_\_\_\_

Yes      No      Blood problem/Anemia  
\_\_\_\_\_

Yes      No      Cancer  
\_\_\_\_\_

Yes      No      Smoking  
\_\_\_\_\_

Yes      No      Hospital admission or surgery  
\_\_\_\_\_

Yes      No      Allergies to medications  
\_\_\_\_\_

Yes      No      Does your child take any medications If yes, please list below.

**Has anyone in your family had the following? If yes, please explain.**

Yes      No      Child born with a heart problem  
\_\_\_\_\_

Yes      No      Heart attack or stroke before age 50 years  
\_\_\_\_\_

Yes      No      High Cholesterol or Blood Pressure  
\_\_\_\_\_

Yes      No      Sudden cardiac death or cardiomyopathy  
\_\_\_\_\_

Yes      No      Heart arrhythmia/Pacemaker.  
\_\_\_\_\_