Patient Name:
DOB:

Patient's Medical History

Please check all that apply

_____ ADD/ADHD
_____ Allergies
_____ Anemia
_____ Asthma
_____ Autism Spectrum disorder
_____ Cancer
_____ Cerebral Palsy
_____ Congenital heart disease
_____ Developmental delay
_____ Diabetes mellitus
_____ Eating disorder
_____ GERD
_____ GYN problems
_____ Headaches
_____ Inflammatory bowel disease
_____ Mental disorder
_____ Otitis Media
_____ Pneumonia
_____ Scoliosis
_____ Seizures
_____ Sickle cell anemia
_____ UTI
_____ Vision problems

Other significant medical history:

_____
_____
_____
_____

Surgical History

Please check all that apply:

_____ Adenoidectomy
_____ Appendectomy
_____ Circumcision
_____ Ear tubes
_____ Fracture surgery
_____ Heart surgery
_____ Inguinal hernia repair
_____ Lymph node biopsy
_____ Tonsillectomy

Other significant surgical history:

_____
_____
_____
_____