Children's Assistance Resources & Education
A Program of the Chandler Unified School District
Healthy Children, Better Communities

MEDICAL HISTORY FORM

PATIENT INFORMATION

Last _____ First _____ Sex: ☐ Female ☐ Male

Date of Birth (Month / Day / Year) _____ Age _____ Race _____

HOUSEHOLD INFORMATION

Please list all the people in the household:

	First Name	Last Name	Date of Birth	Occupation	Education
Father					
Mother					
Other					
Other					
Other					

Have there been any recent changes or stresses in the child's life? ☐ No ☐ Yes
If yes, please explain: _____

Does your child go to a babysitter, preschool, or day care regularly? ☐ No ☐ Yes

BIRTH HISTORY

Birth Weight: _____ Length: _____ Place: _____

During the pregnancy did the mother see a doctor regularly? ☐ No ☐ Yes

During pregnancy did mother: (If yes, explain)		Explanation
Have any medical problems?	☐ No ☐ Yes	
Smoke or drink?	☐ No ☐ Yes	
Use any medications?	☐ No ☐ Yes	
Use alcohol or drugs?	☐ No ☐ Yes	
Have problems with labor/delivery	☐ No ☐ Yes	
How long did the baby stay in the hospital after birth?		

PAST MEDICAL HISTORY

Is the child's general health:	☐ Good ☐ Fair ☐ Poor	
Does the child have any allergies?	☐ No ☐ Yes	
Is the child taking any medications?	☐ No ☐ Yes	
	☐ No ☐ Yes	

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

Has the child ever had any problems with the following, if yes, please explain:		
Eyes/Vision	☐ No ☐ Yes	
Feet	☐ No ☐ Yes	
Digestion/Nutrition	☐ No ☐ Yes	
Ears/Hearing	☐ No ☐ Yes	
Urine/Kidneys	☐ No ☐ Yes	
Joints	☐ No ☐ Yes	
Skin	☐ No ☐ Yes	
Lungs	☐ No ☐ Yes	
Teeth	☐ No ☐ Yes	
Heart	☐ No ☐ Yes	
Seizures	☐ No ☐ Yes	
Repeated Infections	☐ No ☐ Yes	

FAMILY HISTORY

Have any of the child's brothers or sisters died?	☐ No ☐ Yes	If yes, give age and cause:
Have any of the child's blood relatives had the following diseases? If yes, please list family member.		
Heart Disease	☐ No ☐ Yes	
Tuberculosis	☐ No ☐ Yes	
High Blood Pressure	☐ No ☐ Yes	
Kidney Disease	☐ No ☐ Yes	
Allergies/Asthma	☐ No ☐ Yes	
Cancer	☐ No ☐ Yes	
Diabetes	☐ No ☐ Yes	
Mental/Emotional Problems	☐ No ☐ Yes	
Sickle Cell	☐ No ☐ Yes	
Seizures	☐ No ☐ Yes	

DEVELOPMENT

Do you have any concerns about the following? If yes, please explain.		
Development	☐ No ☐ Yes	
Behavior	☐ No ☐ Yes	
Eating Habits	☐ No ☐ Yes	
Sleeping Habits	☐ No ☐ Yes	
School Experiences	☐ No ☐ Yes	
Bathroom/Toilet Habits	☐ No ☐ Yes	
Discipline	☐ No ☐ Yes	
Other(explain)	☐ No ☐ Yes	

IMMUNIZATIONS

Up-to-date?	☐ No ☐ Yes

Parent/Legal Guardian _____ Date _____

Reviewed By _____ Date _____