KACHINA FAMILY PRACTICE CHILD MEDICAL HISTORY (10 AND UNDER)

First Name: _____ Last Name: _____ DOB: _____ Age _____ email : _____

SEX: ◯ M ◯ F RACE: ◯ White ◯ Black ◯ Hispanic ◯ Asian ◯ Native American or Alaskan ◯ Pacific Islander

Pharmacy Name: _____ Cross-Streets: _____ Pharmacy #: _____

Do you have any specific concerns about your childs health? please specify _____

CURRENT MEDICATIONS (INCLUDING OTC)

1.	Dose:	Times / day	2.	Dose:	Times /day	3.	Dose:	Times /day

MED. ALLERGY or VACCINE REACTIONS? Name of the Med. or Vaccine: _____ What reaction occurred?: _____

PREGNANCY AND BIRTH HISTORY Is this child your's by: ◯ birth ◯ adoption ◯ stepchild Other _____

Please indicate any medical problems during pregnancy if applicable _____

Type of Delivery _____ Complications? _____ Birth Weight _____ Was your child premature? _____ If so, how early? _____

Please indicate any medical problems during the baby's newborn period if applicable _____

NUTRITION AND FEEDING Has your child ever had any unusual dietary problems? If so, please specify _____

_____ Type of Milk or Formula _____

SLEEP Hours per night _____ Naps, number and length _____ Any sleeping problems? _____

DEVELOPMENT At what age did your child Sit Alone? _____ Walk Alone? _____ Toilet train? _____

EXPOSURES/HABITS TV- hours per day _____ Video games-hours per day _____ Computer-hours per day _____

Exercise _____ Diet _____ Do any household members smoke? _____

PREVENTIVE CARE Has your child been seen by a dentist? _____ Date of last visit? _____ When was your childs last physical? _____

Please indicate if your child has had any of the following diseases ◯ Chicken Pox ◯ Measles ◯ Mumps ◯ Rubella ◯ Meningitis ◯ Tuberculosis

PAST MEDICAL HISTORY

Please describe any major medical problems and their approximate dates. _____

Please list any surgeries your child has had and the approximate dates. _____

Has your child ever been hospitalized? if yes - please specify when and why? _____

FAMILY MEDICAL HISTORY

Mother---------->	continued	Father---------->	continued	Brothers	Sisters
Alive	Alcoholism	Alive	Alcoholism	Alive	Alcoholism
Deceased,Age:	Diabetes, Type:	Deceased,Age:	Diabetes, Type:	Deceased,Age:	Diabetes, Type:
Alzheimers	High Blood Pressure	Alzheimers	High Blood Pressure	Alzheimers	High Blood Pressure
Arthritis	Migraine	Arthritis	Migraine	Arthritis	Migraine
Asthma	Obesity	Asthma	Obesity	Asthma	Obesity
Cancer,Type:	Osteoporosis	Cancer,Type:	Osteoporosis	Cancer,Type:	Osteoporosis
Heart Disease	Kidney Disease	Heart Disease	Kidney Disease	Heart Disease	Kidney Disease
High Cholesterol	Stroke	High Cholesterol	Stroke	High Cholesterol	Stroke
Depression	Thyroid Disorder	Depression	Thyroid Disorder	Depression	Thyroid Disorder

SOCIAL HISTORY What grade is your child in? _____ What grades does your child get? _____ Are there problems at school? _____

Who lives at home with your child? _____ Are there problems at home? _____ if so, please specify _____

How did you hear about Kachina Family Practice? _____