SHELBY CHILDREN'S CLINIC 709 N. Dekalb St. Shelby, NC 28150 980-487-2100

PATIENT HISTORY SHEET

Date_____
Patient Name_____ DOB_____ File #_____
Who lives in your house/relationship to child _____
_____
_____

PAST HISTORY

Allergies_____
Birth Weight_____ List problems with pregnancy or as a newborn _____
Hospitalizations/surgeries_____
Medical problems (circle if had/has): asthma, allergies, ear infections, eye problems, constipation, convulsions, head injury, migraines, pneumonia, muscle/bone problems, UTI/bladder infection, bed wetting Other _____
List any concerns you have had/do have about your child's development (walking, talking, etc.)_____
List any medicines (prescription or over the counter) or supplements you child takes
_____

FAMILY HISTORY (list relationship who have—for example: sister,brother,uncle,grandfather)

Allergy/hayfever _____
Anemia _____
Arthritis (early age, lupus, rheumatoid) _____
Asthma/inhaler use _____
Bleeding/bruising problems _____
Cancer (type) _____
Child abuse/domestic violence _____
Childhood deaths/cause _____
Cholesterol elevated/high _____
Diabetes/sugar _____
Drug or alcohol problems _____
Heart attacks/disease _____ If so, anyone less than 50 yrs old _____
Hypertension/high blood pressure_____
Mental illness/type_____
Mental retardation/"slow learner" _____
Seizure/epilepsy _____
Sickle cell anemia _____
Sickle cell trait _____
Thyroid problems _____
Tuberculosis _____
Vision or hearing problems _____
Other (list) _____