PATIENT HISTORY/ASSESSMENT FORM

GEBHARDT PIERCE BOESCH

Children/Minors

Parent/guardian, please answer all questions to the best of your ability.

Health Care Provider: _____ **Date:** _____

Patient name: _____ Date of Birth: _____ Sex _____ M _____ F
Address: _____ Home phone: _____ (father/mother)
City/State/Zip: _____ Patient lives with (circle one): father / mother / both
Father's name: _____ Employer: _____ Work phone: _____
Address (if different from child's) _____ Father's home phone (if different) _____
City/State/Zip: _____ Father's cell phone _____
Mother's name: _____ Employer: _____ Work phone: _____
Address (if different from child's) _____ Mother's home phone (if different) _____
City/State/Zip: _____ Mother's cell phone _____

Legal custody (circle): mother / father / both / other (name: _____)

Preferred method of contact (circle) cell phone home phone work phone father / mother

ALLERGIES: list any allergies the patient has to medications, foods, or environment: _____

_____

Does the patient have a latex sensitivity or allergy (band-aids, latex balloons or gloves, etc.)? ___ yes ___ no

CURRENT MEDICATIONS: Please list all medications and dosages (if known) that the patient is currently taking. List ill prescription, over-the-counter, and vitamins or other supplements _____

_____

_____

CHILD'S MEDICAL HISTORY: Indicate if any of the following are current or past problems:

Condition	Past Problem	Current Problem	Explain current symptoms or treatment
Asthma	____ yes ____ no	____ yes ____ no	_____
Hayfever / seasonal allergies	____ yes ____ no	____ yes ____ no	_____
Diabetes	____ yes ____ no	____ yes ____ no	_____
Heart problems	____ yes ____ no	____ yes ____ no	_____
Seizures	____ yes ____ no	____ yes ____ no	_____
Skin rashes/ eczema	____ yes ____ no	____ yes ____ no	_____
Acne	____ yes ____ no	____ yes ____ no	_____
ADHD	____ yes ____ no	____ yes ____ no	_____
Weight problems / anorexia or obesity	____ yes ____ no	____ yes ____ no	_____
Ear infections	____ yes ____ no	____ yes ____ no	_____
Throat infections	____ yes ____ no	____ yes ____ no	_____
Joint / muscle problems	____ yes ____ no	____ yes ____ no	_____
Developmental disabilities	____ yes ____ no	____ yes ____ no	_____
Other: _____	____ yes ____ no	____ yes ____ no	_____

Any problems at birth: ____ yes ____ no Explain: _____
Premature: ____ yes ____ no # of weeks premature _____
Feeding problems: ____ yes ____ no Explain: _____

(OVER —>)

MEDICAL HISTORY CONTINUED:

Past surgeries and dates: _____

_____

_____

Questions *** Please provide a copy of the vaccination record.**

Are vaccinations up to date? ____ yes ____ no

Has the patient had:

Flu ____ yes ____ no Date: _____

Tetanus ____ yes ____ no Date: _____

Any smokers in the home? ____ yes ____ no

Tobacco use: ____ yes ____ no How long? _____ Amount: _____

Alcohol use: ____ yes ____ no How long? _____ Amount: _____

Street drugs: ____ yes ____ no How long? _____ Type: _____

Does the patient always use seat belts/ child safety seat? ____ yes ____ no

Does the patient always use a helmet when riding a bike? ____ yes ____ no

Any history of physical, sexual, or emotional abuse? If so, please explain: _____

_____

Any other problems or concerns not yet listed: _____

_____

FAMILY HISTORY:

Relation	age	General health / any problems	Cause of death if deceased
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____

Signature of the person completing this form: Relationship:

_____ _____

HEALTH CARE PROVIDER REVIEW: INITIALS _____ DATE _____

_____ _____

_____ _____

_____ _____

Patient name: _____