Health Ministries	Clinic CENTER DOB: Today's	r ic History Name: Date:	Form//////	/		
Medical History						
How old was the mother when the pa	tient was born?					
Which pregnancy was this child for t	he mother?					
Did the mother use any of these subs ☐ Alcohol—How much? ☐ Illegal Drugs—What? ☐ Smoking—How much?		ncy?				
Was this child born full term? If no, how early/late?						
How much did the child weigh at bir	:h?					
Was the child healthy at birth?						
Has the child ever been hospitalized Age of Child	? Cause of hospital	ization				
Has the child ever had surgery? Age of child	Туре	Reaso	n for surgery			
ALLERGIES: Section Yes No List all reactions to medicine, foods and other agents.						
Allergy	Reaction or Side I	Effect				
Does this child use any medications on a routine basis?						
•	Dose/Frequency		Reason			
Does this child have any history of the following? □ Allergies						

- □ Asthma
- □ Attention Deficit Disorder (ADD/ADHD)
- □ Seizures
- Eczema Atopic Dermatitis
- □ Recurrent Ear Infections
- □ Other (specify)

Immunizations:

Are Immunizations up to date?

Please supply a copy of record.

Development: Do you have any concerns about your child's development?

Name Age Relationship to the child			
Social History: Please list all persons who live with the child Name Age Relationship to the child Name Age Relationship to the child Relationship to the child Relationship to the child Relationship to the child Relationship to the child Relationship to the child Relationship to the child Relationship to the child's family members Relationship to the following? How many? What? How many? What? Are there any smokers in the home? Relationship the following? How many? What? Family History: Relation Deficit Disorder (ADD/ADHD) Birth Defects Asthma Attention Deficit Disorder (ADD/ADHD) Birth Defects Death before age 21 Cause Cause	If school age: Grade School		
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Image: Second	Please list all persons who live with the child		
Do you have any pets in the home?	Name Age	Relationship to the child	
Image: Second State Sta			_
Do you have any pets in the home?			_
Do you have any pets in the home? How many? What? Are there any smokers in the home? Smoke outside only? Family History: Do any of the child's family members (parent, sibling) have any of the following? Allergies Allergies Birth Deficit Disorder (ADD/ADHD) Birth Defects Detath before age 21 Cause Eczema - Atopic Dermatitis Seizures Other (specify) What concerns would you like to discuss with the doctor today? Intertify that the above information is correct to the best of my knowledge. I will not hold my doctor or clinic staff responsible for any errors or omissions that I may have made in completing it. Signature of Parent or Guardian Date			
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Are there any smokers in the home?			_
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Are there any smokers in the home?	How many? What?		
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HMC Staff Name (PRINT) HMC Staff Signature Date	HMC Staff Name (PRINT)	HMC Staff Signature	Date