Eureka PEDIATRICS

HEALTH HISTORY

Patient's Name:_____ **Date of Birth:** _____

Preferred Pharmacy:_____ **Location:**_____

Has your child ever had any of the following: (If "yes" please explain):

A serious illness or medical condition? _____

A serious accident or injury? _____

An operation? _____

A frequently recurring illness? _____

A concussion, if so, how many? _____

Is your child current on their vaccinations? _____

Current Medications: Please list any medication that the patient is using including over the counter medications, vitamins, supplements and contraception.

Medications	Dose/Amount	How many times per day

Medication/Food Allergy: _____

Reaction:_____

Family Medical History: Please indicate which family member

Seasonal Allergies:_____ **Asthma:**_____
High Blood Pressure: _____ **Cancer:**_____
Early Heart Disease:_____ **Eczema:**_____
High Cholesterol:_____ **Seizures:**_____
Hearing Problems:_____ **Diabetes:**_____
Headaches/Migraines:_____ **Kidney Disease:**_____
Behavioral Problems:_____ **Family Violence:**_____