Sunshine Medical Care

Comprehensive Patient Health History Questionnaire (PEDIATRICS)

Today's Date: ____/____/_____

Patient's Name: _____ DOB: ____/____/_____

Briefly, what are you seeing the doctor about today? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Do you have any Allergies to any Medications? □ No Allergy

Medication Name:	Type or reaction:
_____	_____
_____	_____

Are you currently taking any Medication(s)? □ None

Medication Name:	Strength:	Directions:
_____	_____	_____
_____	_____	_____

Pharmacy: (Required) Name: _____ Location:_____

Please list any Past Medical Problems: □ None

Medical Condition:	Date or Age Diagnosed:
_____	_____
_____	_____

Have you had any Surgeries? □ None

Type of Surgery:	Date or Age Performed:
_____	_____
_____	_____

Are there any known medical conditions in your Family History? □ None

Medical Condition:	Family member:
□ Hypertension	_____
□ High Cholesterol	_____
□ Diabetes	_____
□ Other: (List _____)	_____

SOCIAL HISTORY:

School Grade: _____ Living Situation: Lives with _____

Primary Care Physician? Name: _____ Phone number: _____

IMMUNIZATIONS: Up to Date? □ Yes □ No

Thank-you for taking the time to complete this form!