KACHINA FAMILY MEDICINE CHILD MEDICAL HISTORY (UNDER 10)

Personal Information

Full Name: _____ Today's Date: _____
Last First Birthdate Age

Email: _____ Preference for Rx: ☐ 30 day or ☐ 90 day supply

Pharmacy: _____
Name & Cross Streets *Pharmacy Phone Number*

Current Medications: *Dose Times/day* *Dose Times/day*

1. _____ 3. _____

2. _____ 4. _____

Medication allergies or vaccine reactions: _____

Medical History

Pregnancy & Birth This child is yours by ☐Birth ☐Adoption ☐Stepchild ☐Other: _____

Any medical problems/complications during pregnancy? _____

Type of Delivery: ☐Vaginal or ☐C-section ☐Full Term or ☐Premature: _____

Any medical problems during newborn period? _____

Any additional medical problems? _____

Surgeries & approx. date: _____

Other hospitalizations & approx..date: _____

Indicate if your child has had: ☐Chicken Pox ☐Measles ☐Mumps ☐Rubella ☐Meningitis ☐Tuberculosis

Social History & Lifestyle

Who does the child live with? _____ Hobbies? _____

Pets? _____ Years in AZ? _____ Previous states? _____

What grade is your child in? _____ School performance/grades? _____ Any problems at school? _____

Exercise: ☐None Types: _____ Frequency: _____ days per week. Hours/day on screens: _____

Nutrition: ☐Excellent ☐Good ☐Average ☐Needs Improvement ☐Poor ☐Lots of Fast Food

Any dietary concerns? _____ Does anyone in the household use: ☐Cigarettes ☐Illicit Drugs

Any problems/concerns at home? _____

Family Medical History

☐ **ADOPTED (Skip to Preventative Care)**

Mother: ☐Alive ☐Deceased Age: _____		**Father:** ☐Alive ☐Deceased Age: _____		**Siblings:** Number of Brothers: _____ Sisters: _____	
Cause of death: _____		Cause of death: _____		Cause(s) of death: _____	
Medical Issues:		Medical Issues:		Medical Issues:	
☐ADD/ADHD	☐High Blood Pressure	☐ADD/ADHD	☐High Blood Pressure	☐ADD/ADHD	☐High Blood Pressure
☐Anxiety	☐Migraines	☐Anxiety	☐Migraines	☐Anxiety	☐Migraines
☐Asthma	☐Obesity	☐Asthma	☐Obesity	☐Asthma	☐Obesity
☐Depression	☐Thyroid Disorder	☐Depression	☐Thyroid Disorder	☐Depression	☐Thyroid Disorder
☐Heart Disease	☐Other:	☐Heart Disease	☐Other:	☐Heart Disease	☐Other:
☐Cancer, Type:		☐Cancer, Type:		☐Cancer, Type:	

Preventative Care

Date of last Physical/Well Visit: _____ Is your child up to date on vaccinations? ☐Yes ☐No

PLEASE BRING A COPY OF YOUR CHILD'S SHOT RECORD TO THE APPOINTMENT

How did you hear about us? _____

Signature of Parent/Guardian: _____ Date: _____ Relationship to Patient: _____