Name:____ **Date of Birth:**_______________

Current Medications: ☐ See attached

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

Pharmacy #: Local: ____
Mail In: ____

Home Life: Child lives with: ☐Mom ☐Dad ☐Sibling(s) ☐Grandparent ☐Other:__________________

Parents Marital Status: ☐ Married/live together ☐Divorced/live apart

Personal and Family History: ☐ Adopted/Unknown Family History

Indicate who has been diagnosed with or takes medication for the condition: **Me** (patient), Patient's **M** (mom), **F** (father), **S/B** (sister/brother), **MGM/MGF** (mom's mom/dad), **PGM/PGF** (dad's mom/dad), **MA/MU** (mom's sister/brother), **PA/PU** (dad's sister/brother). Use back of the page for additional information.

☐ Diabetes________________________________ ☐ Asthma______________________________
☐ Hypertension____________________________ ☐ Arthritis_____________________________
☐ High Cholesterol_________________________ ☐ Migraines____________________________
☐ Heart Attack____________________________ ☐ ADD_________________________________
☐ Stroke_________________________________ ☐ Allergies_____________________________
☐ Hypothyroid_____________________________ ☐ Reflux_______________________________
☐ Cancer (type)____________________________ ☐ Depression/Anxiety______________________
☐ Other:____

Personal History:

Other Medical Providers & specialty:____________________________________ ☐ attached

Preventative Tests: ☐ shot record provided

Surgeries ☐ tonsil/adenoids ☐ appendix ☐ tubes in the ears ☐ Other:____________________

Allergies: ☐ no known allergies ☐ latex ☐ food ☐ seasonal ☐ medications:______________

____

Social History (teens):

Tobacco: ☐ never ☐ current ☐ past use of cigarettes/smokeless tobacco/vape/cigars (circle)

Amount used? ______________________________Age/date start/stop? ____________________

Alcohol: ☐ none ☐ rare ☐ currently drink (# drinks) ______ per day/week (circle) ______________

Other drugs: ☐ none ☐ current/past use of ____

Sexual History (teens): ☐ not applicable ☐ sexually active - interested in: ☐ boys ☐ girls ☐ both

Contraception: ☐ condom ☐ pill ☐ IUD other: ____________________________________

Female Patients: Indicate #: _____ pregnancies _____ births _____miscarriage/abortion

Gyn history: date/age of 1st menses ________ # days between the start of your periods ________
periods in the last year _________

I understand minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

____ ____________________
Patient/Guardian Signature Date