Patient History Form

Patient Name: ____ DOB: _________________

Do you see any doctors outside of Mercy? Yes No Where? ________________________

Preferred Pharmacy Name & Phone Number: ____________________________________

Reason for visit today: ____

Child History

Does your child have any allergies? **Yes No To what?** _____________________________

Are your child's Immunizations up to date? **Yes No**

Has your child ever had surgery? **Yes No Why?** ______________________________

Any reactions to anesthesia? **Yes No**

What mediations has your child tried, please include dosage.

- o Nexium __________ o Prilosec__________ o Prevacid __________ o Zantac __________
- o Pepcid ___________ o Miralax _________ o Naproxen (Aleve) ___________
- o Motrin ___________ o Tylenol _________

REVIEW OF SYSTEMS: (PLEASE CIRCLE ALL THAT APPLY)

GASTROINTESTINAL	**CARDIOVASCULAR**	**RESPIRATORY**	**INTEGUMENTARY**	**ENDOCRINE**	**NEUROLOGICAL**
DIARRHEA	HYPERTENSION	ASTHMA	RASH/ LESIONS	DIABETES	SEIZURES
CONSTIPATION	HYPOTENSION	TRACHEOTOMY	WOUNDS	THYROID DISORDERS	MIGRAINES/ HEADACHES
HEARTBURN	IRREGULAR HEARTBEAT	**ENT**	FATIGUE	**GENITOURINARY**	**MUSCULOSKELETAL**
TROUBLE SWALLOWING	CHEST PAIN	CHRONIC EAR INFECTIONS	RECURRENT FEVER	KIDNEY DISEASE	JOINT PAIN
NAUSEA/VOMINING	**OTHER** ______________	RECURRENT SORE THROAT/STREP	**OTHER** ______________	FREQUENT UTI'S	JOINT SWELLING
OTHER ______________	**OTHER** ______________	NOSE BLEEDS	**OTHER** ______________	**OTHER** ______________	JOINT STIFFNESS

(IMMEDIATE FAMILY ONLY) Family Member

Illnesses or Medical Conditions	Relationship to patient	Name of family member
Colon/Rectal Cancer YES NO		
STOMACH PROBLEMS YES NO		
ANESTHESIA REACTION YES NO		
COLON POLYPS YES NO		
ULCERATIVE COLITIS YES NO		
CROHN'S DISEASE YES NO		
CELIAC DISEASE YES NO		
ARTHRITIS YES NO		

Please list any prescription or over-the-counter medications your child is currently taking:

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