A kidZ Clinic

Health History

Name (Last)_____ (First) _____
Date of Birth _____ Gender M/F
Do you have any allergies? Y/N If yes, please list your allergies and reactions _____
Do you take any medications Y/N If yes, please list _____
Are you under medical supervision for any conditions? Y/N If yes, please list _____
Do you have or have you ever had any of the following:

Please Explain:

	Condition	**Yes**	**No**
1	Been hospitalized?		
2	Had surgery?		
3	Been told you had a heart condition?		
4	Have you ever passed out or nearly passed out during exercise?		
5	Have you ever had chest discomfort, pressure, or pain during exercise?		
6	High blood pressure		
7	High cholesterol		
8	Do you have a heart murmur?		
9	Have you felt anxious lately?		
10	Does anyone in your family have a heart condition, had a stroke, or died suddenly before the age of 50?		
11	Do you have severe acne?		
12	Have you been diagnosed with scoliosis?		
13	Have you ever been diagnosed with asthma?		
14	Were you born with a kidney, eye, testicle, or any other organ disease?		
15	Have you ever had a seizure?		
16	Do you have headaches?		
17	Have you had any blood disorders or anemia?		
18	Do you wear glasses or contact lenses?		
19	Do you regularly see a dentist?		
20	Do you have a regular sleeping pattern?		
21	In the last two weeks have you felt depressed?		
22	Have your ever been diagnosed with a thyroid disorder?		
23	Have you ever been diagnosed with diabetes?		
24	Have you or anyone in your family been treated or diagnosed with a psychiatric disorder?		

Do you have any family or cultural beliefs you would like us to know about to help us better care for your needs?

What makes your family unique?

I have read and understand the above questions and have answered them to the best of my knowledge.

Patient/Parent Signature_____ Date_____