Silver Psychiatric Services

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MEDICAL HISTORY FORM
(Child and Adolescent)

This form is to be filled out by parent or guardian.

Child's Name: _____ **Today's Date:** _____

Please provide the name and address of the child's physician or medical clinic:
Name: _____ **Phone:** _____

Address: _____

_____

Date of most Recent Physical Exam: _____

Has your child had or been treated for any of the following: Please check and give approximate date.

- — Asthma
- — Hay Fever
- — Diabetes
- — Diptheria
- — Dizziness
- — Epilepsy (Seizures)
- — Frequent colds
- — Mononucleosis
- — Operation
- — Allergies (Describe below)
- — Frequent Headaches
- — Frequent Stomachaches
- — Fainting Attacks
- — Staring Attacks
- — Heart Disease
- — Heart Murmur
- — Ulcer/Colitis
- — Rheumatic Fever
- — Head Injuries
- — Other Major Injuries
- — Hepatitis
- — Measles
- — German Measles
- — Mumps
- — Pneumonia
- — Polio
- — Tuberculosis
- — Major Weight Loss/Gain
- — Kidney/Urinary Problems

Please List all Hospitalizations: _____
_____

Please List all Current Medications: _____
_____

Additional Details: _____
_____

Family History:
Was a family member ever treated for: Please check all that apply.

- — Heart Disease
- — Stroke
- — Liver Disease
- — Bleeding Problems
- — High Blood Pressure
- — Cancer
- — Major Illnesses
- — Tuberculosis
- — Diabetes
- — Kidney Disease
- — Major Operations
- — Thyroid Disease

Additional Details:

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