# New Patient Medical History Form Child Under 10 years

Childs Name: _____ DOB: _____

Please complete the following health related information for your child to assist your doctor in providing them with the best possible care. The nurse will meet with you shortly to check weight and height and help with any questions you are not sure about. We understand some of these questions are personal but they can have direct impact on your child's health and wellbeing and will help your doctor in caring for their health.

## ***Allergies: (Must be completed)***

☐ Nil known allergies

☐ Allergic to: _____ Reaction: _____

_____ Reaction: _____

## ***Medical History:***

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

## ***Family Medical History***

☐ Unknown (eg adopted) ☐ No significant family history

Mother alive? ☐ Yes ☐ No Age of death_____ Cause of death_____

Father alive? ☐ Yes ☐ No Age of death_____ Cause of death_____

**Significant family medical history:**

Mother: ☐ Heart Disease ☐ Breast cancer ☐ Stroke ☐ Diabetes
☐ Bowel Cancer ☐ Hypertension ☐ Depression
☐ Other_____

Father : ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Diabetes
☐ Bowel Cancer ☐ Depression ☐ Other _____

## ***Sex:***

☐ Male ☐ Female

***Parent/Guardian/Carer Signature:_____ Name:_____ Date:_____***

***Office Use Only and Nurse Examination findings:***

***Weight:_____ Height: _____***

***Entered By: Nurses Name: _____ Date: _____***