105 5th Avenue East
Scobey, MT 59263
406-487-2296

Your Medical History (Ages 16 & below)

(please check all that apply)

Name:_____
Date of Birth:_____
Phone:_____

Today's Date:_____
Time:_____

- ☐ Abdominal Pain, chronic
- ☐ ADD
- ☐ ADHD
- ☐ Allergic Rhinitis
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Celiac Disease/Sprue
- ☐ Cerebral Palsy
- ☐ Chronic Otitis Media (ear infections)
- ☐ Chronic Urinary Tract Infections
- ☐ Constipation
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Developmental Delay
- ☐ Diabetes Mellitus, Type I
- ☐ Diabetes Mellitus, Type II
- ☐ Down Syndrome
- ☐ Eczema
- ☐ GERD (reflux)
- ☐ Heart Murmur
- ☐ Hydrocephalus (water on the brain)
- ☐ Hydronephrosis (enlarged or swelling of kidney)
- ☐ Hyperthyroid (overactive thyroid)
- ☐ Hypothyroid (low thyroid)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Speech Delay
- ☐ Tonsillar Hypertrophy (enlarged tonsils)
- ☐ Vesicoureteral reflux (urinary backflow)

Your Family Medical History

Are you adopted? Yes/ No **If no, continue below**. If **yes**, continue only if you know birth family's medical history

	Father	Mother	Brother	Brother	Sister	Sister
List Family member 1st name in column						
If living, birth date, birth year or age if known						
If not living, age at death						
If not living, cause of death						
Family Medical History (put a check in the column of those that apply)						
Asthma						
Breast Cancer						
Colon Cancer						
Coronary Artery Disease						
DVT/ Blood Clots						
Diabetes						
Heart Attack less than 50 years old						
High Cholesterol (Hyperlipidemia)						
High Blood Pressure (Hypertension)						
Heart Attack greater than 50 years old						
Ovarian Cancer						
Prostate Cancer						
Stroke						
Unknown Health Status						
Other health issues not listed (list)						

Do not file – shred after data entry

OVER ►

Your Social and Surgical History

Tobacco Use-answer for all ages:
Smoker (other than self) in the Household? (check one)
☐ Yes ☐ No

Tobacco Use Ages 13 and above: (check any that apply)
☐ Never ☐ Current ☐ Past
(If Past, Check below about when you quit)
☐ Quit, over 1 year ☐ Quit, Used within past year

What type: (check any that apply)
☐ Chewing Tobacco ☐ Cigarettes
☐ Cigars ☐ Pipe

Amount Used per day: _____
Started at what age: _____
Stopped at what age:_____

Alcohol Use- answer for all ages:
Concerns about alcohol use in the household?
Yes/No (circle one)

Alcohol Use Ages 13 and above: (check any that apply)
☐ Never ☐ Current ☐ Past ☐ Recovering Alcoholic

Type of Alcohol: (check any that apply)
☐ Beer ☐ Wine
☐ Liquor ☐ Other _____

Frequency:
☐ 1-2 drinks a day
☐ Greater than 2 drinks a day
☐ Infrequent or Seldom

Started at what age: _____
Stopped at what age:_____

Substance Abuse-all ages:
Concerns about substance use in the household?
(circle one)Yes/No

Substance Abuse Ages 13 and above: (check any that apply)
☐ Never ☐ Current ☐ Past

What type: (check any that apply)

Amphetamines	☐ LSD
Cocaine	☐ Marijuana
Ecstasy	☐ Methamphetamines
Heroin	☐ Narcotics
Inhalants/Glue/ Solvents	☐ PCP
	☐ Sedatives
Ketamine	☐ Other:

Frequency: (check any that apply)
☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Started at what age: _____
Stopped at what age:_____

IV Drug Use: ☐ Never ☐ Current ☐ Past

Home/Environment: (check any that apply)
Lives with:
☐ Alone ☐ Children ☐ Father ☐ Mother
☐Siblings ☐ Significant Other ☐ Spouse
☐Other: _____

Living Situation: (check any that apply)
○ Home/Independent
○ Home with Assistance
○ Assisted Living Facility
○ Homeless/Shelter
○ Group Home

Home/Environment continued:
Mother Name and Contact Number(s): _____
_____

Father Name and Contact Number(s): _____
_____

Guardian/POA Name and Contact Number(s):
_____

Cultural Preferences: (check any that apply)
☐ No blood products
☐ Dietary restrictions
☐ Other _____

Pets in Home? Yes/No (circle one)

Type of pets: (check any that apply)
☐ Cat
☐ Dog
☐ Bird
☐ Other (list)_____

Does pet sleep in patient's room? (circle one) Yes/No

Employment/School:
Young Children only-Attends Daycare? (circle one) Yes/No

School Type: (check any that apply)
☐ Public School ☐ Special Education
☐ Home School ☐ IEP
☐ Gifted ☐ Private School
☐ Other (list)_____

Extracurricular Activities/Sports: _____
_____

Employment for Ages 14 and above: (check any that apply)
☐ Employed
☐ Retired
☐ Student
☐ Homemaker
☐ Unemployed
☐ Disabled
What type of work: _____
Highest education:_____

Check box next to procedures or surgeries child has had. Please include the year if known.

Major Procedure/Surgery	Year
☐ None	
☐ Appendectomy (appendix removed)	_____
☐ Tonsillectomy (tonsils removed)	_____
☐ Adenoidectomy (adenoids removed)	_____
☐ Other surgeries-list _____	_____
_____	_____