Ascension
Columbia St. Mary's

Kohl's Wellness Center
Pediatric Medical History (Birth - 17 yrs)

Name (Last, First, Middle)	Social Security No.	Date of Birth	Age	Sex	Date of Exam

Home Address	Home Phone No.	Cell Phone	Email Address

Emergency Contact

Name of Emergency Contact	Address of Contact	Phone No. of Contact	Relationship

Primary Care Physician

Name of Personal Physician	Address of Physician	Phone No. of Physician

☐ Please check this box if you will be using the Wellness Center as your Primary Care

The information in this form will be kept strictly confidential and no identifiable medical information about you will be released without your written authorization, except in cases of a medical emergency or as required by law.

Allergies

Is your child allergic to any of the following? ☐ No known allergies

☐ Medications? ☐ Foods? ☐ Pollen? ☐ Dust or molds?

☐ Animals? ☐ Latex? ☐ Other?

Please specify:____

Does your child use sunscreen? ☐ Yes ☐ No

Does your child use a carseat/seatbelt? ☐ Yes ☐ No

Please include all prescription medications, over the counter medications, supplements and/or vitamins for your child

Medication	**Dose**	**Reason for Use**

Surgical History

Surgery ______ Date ______

______

______

______

Please check if any of these conditions/diagnosis apply to your child and/or family members?

	SELF	FAM HX	Which Family Member		SELF	FAM HX	Which Family Member
Heart Murmur				Positive TB Skin Test			
Cataracts				Sexually Trans Disease			
Glaucoma				Ulcer(s)			
Heart Attack				Gallstones			
Rheumatic Fever				Hepatitis			
High Blood Pressure				Kidney Stones			
Pneumonia				Bladder/Kidney Infx			
Asthma				Arthritis			
Emphysema				Gout			
High Cholesterol				Herniated Disk			
Thyroid Issues				Active Tuberculosis			
Diabetes				Anemia			
Head Injury				Tumors (benign)			
Migraines				Cancer			
Seizures				Alcoholism			
Stroke				Other Addiction			
Depression/Anxiety				Adopted			

For YES to any, please indicate diagnosis and any current limitations

______

______

Is your child's current vaccine status up to date? ☐ Yes ☐ No ☐ Unknown

I certify that the information on the Medical History form is true, complete and correct.

Patient Name (Please Print):______

Signature of Parent/Guardian:______ Date:______