Billings Clinic

801 North 29th Street
Billings, MT 59101
238-2500 / 1-800-332-7156

Child's/Patient's Medical History (Ages 17 & below)

(please check all that a Medical Provider has told you are Patient's Medical Problems)

Name:______________________________
Date of Birth:__________________________
Phone:_____________________________

Today's Date:______________________
Time:______________________

- ☐ No Known Problems
- ☐ 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)
- ☐ Other (list)______________________

Child's/Patient's Birth Family Medical History

Is child 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)						
No Health Problems						
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						
Genetic Disorders (list type below person)						
Unknown Health Status						
Other health issues not listed (list)						

Do not file – shred after data entry

OVER ►

Child's/Patient's Social and Surgical History

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

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

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

For patients 13 and above, answer below regarding their personal substance use:

Tobacco Use Ages 13 and above: (check any that apply)
☐ Current daily ☐ Current some ☐ Former smoker
☐ Never ☐ Smoker status unknown ☐ Unknown if ever smoked

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

Amount Used per day: _______________

Started at what age: _______
Stopped at what age:_______

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 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 ○ Foster Home
○ Home with Assistance ○ Group Home
○ Assisted Living Facility ○ Homeless/Shelter

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

Father Name and Contact Number(s): __________
____

If patient does not live with parents, list below:
Other Family Member Name and Contact Number(s):
____

Guardian/POA/Foster Parent 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
☐ Student
☐ Unemployed
☐ Disabled
What type of work: ____________________
Number of hours worked per week ___________
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)	______
☐ Tympanostomy tubes (ear tubes) R L	______
☐ Other surgeries-list _______________	______
_______________________	______