GLENSIDE MEDICAL ASSOCIATES, P.C.
4000-A GLENSIDE DRIVE
RICHMOND, VIRGINIA 23228
(804) 262-4763

Children's Health History
Ages 12 and Under

Patient Information

Name: _____ **Date:** _____

Date of Birth: _____

Does the patient currently have or has the patient ever had the following conditions? Please indicate "yes" by circling the appropriate condition.

1. **Diabetes**
2. **Heart disease or heart murmur**
3. **Asthma, Tuberculosis, Bronchitis, Frequent coughs**
4. **Epilepsy, seizures, head injury**
5. **Difficulty with hearing, frequent coughs, sore throats**
6. **Frequent earaches, tubes in ear**
7. **Difficulty with vision, wear eye glasses/contacts**
8. **Anemia, sickle cell, other blood problems**
9. **Constipation, Diarrhea, Ulcers**
10. **Arthritis**
11. **Bladder or Kidney infections, blood or urine**
12. **Allergies**
13. **Allergy Shots**
14. **Are immunizations up to date?**
15. **Please indicate operations or surgical procedures:**
