Catherine Screnci MD PLLC **Today's Date: _____**

Patient Medical History Form

Patient Name: _____ Date of Birth: _____

History Question	YES	NO	Comments
Serious injuries or accidents			
Surgeries			
Hospitalizations			
Chicken Pox			
Frequent ear infections			
Problems with ears or hearing			
Asthma, bronchitis, or pneumonia			
Animal allergies			
Outdoor allergies			
Indoor allergies			
Heart problems or heart murmurs			
Anemia or bleeding problems			
Blood transfusion			
Frequent abdominal pain			
Constipation requiring doctor visit			
Bladder or kidney infection			
Bed-wetting (after age of 5)			
If female, have menstruation periods started?			
If female, are there any problems with menstrual period?			
Chronic or recurrent skin problems (acne, eczema, psoriasis, etc.)			
Frequent headaches			
Convulsions or other neurological problems			
Diabetes			
Thyroid or other endocrine problems			
Use of alcohol or drugs			
Other significant problems			

SOCIAL HISTORY QUESTIONS

History Question	YES	NO	Comments
Smoking status			
Second-hand smoke			
Lead Exposure			