FAMILY DOCTORS OF VICKSBURG PC
13320 NORTH BOULEVARD ST. VICKSBURG MI 49097 269-649-2012 FAX: 269-649-3752

SCHOOL AGE PHYSICAL (5 AND UP)

Date: _____ Date of Birth: _____
Name: _____ Nickname: _____
Name of School/Daycare: _____
Allergies: _____

Birth History

Birth Weight: _____ Was this child born on time_____ Early_____ Late_____
Were there any complications during pregnancy/delivery? _____
Did your child have to stay in the hospital for more than one night? _____

Social History

How would you describe your family situation? Single_____ Married _____ Widowed _____ Divorced _____
If divorced, is there shared custody? _____
Does anyone smoke at home? _____ Any pets at home? _____
Who lives in the home with your child? _____
Any recent changes in your home situation (marriage, death, divorce) _____
What is your drinking water source? Well_____ City_____ Bottled_____

Medical History

Is your child currently being treated for any medical problems? _____
Any operations or hospitalizations? _____
List any medications your child is taking: _____
_____
Does your child take: Vitamins: _____ Fluoride: _____
Does your child have any special needs? _____
Is your child up to date with their immunizations? _____ Please provide us with a copy of their record.
Does your child have a history of:

	YES	NO		YES	NO
Chest Pain			Recurrent Headaches		
Asthma or Wheezing			Recurrent Ear Infections (>3 a year)		
Shortness of breath with exertion			Recurrent sore throat		
Head injury			Recurrent abdominal pain		
Loss of consciousness			Serious accidents		
Orthopedic injury (broken bones)			Chicken pox		
Heart murmur			Tobacco use		
Seizure			Ephedra use		
Passed out with exertion			Alcohol use		
Sensitivity to bee sting			Marijuana use		
Vision/hearing impaired			Other drug use		
Depression/anxiety			Any physical defect (one kidney, scoliosis etc)		

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Developmental History

How old was your child when he/she first walked? _____
How is your child doing academically? _____
Does your child have lots of friends? _____ Does your child like to read? _____
What are your child's hobbies? _____
Does your child seem to have trouble concentrating in school? _____
Have you discussed drug use with your child? _____
Have you discussed sexual development with your child? _____

Family History

	LIVING		**DECEASED**	
	Age	Health	Age	Cause of death
Father's Father				
Father's Mother				
Mother's Father				
Mother's Mother				
Father				
Mother				
Brothers				
Sisters				

Has any blood relative had any of the following?

CONDITION	YES	NO	UNSURE	CONDITION	YES	NO	UNSURE
High Cholesterol				Uncontrolled bleeding			
High blood pressure/Hypertension				Anemia or low blood count			
Heart disease				Hemachromatosis			
Heart attack				Skin Cancer			
Stroke				Breast Cancer			
Asthma				Prostate Cancer			
Emphysema				Uterine Cancer			
Colon Cancer				Ovarian Cancer			
Colon Polyps				Other Cancer			
Polycystic Kidney Disease				Sickle Cell Anemia			
Osteoporosis				Easy bleeding/bruising			
Hip Fracture				Arthritis			
Hay Fever or Eczema				Nervous breakdown			
Diabetes				Alcoholism			
Obesity				Panic disorder			
Thyroid Disease				Schizophrenia			
Seizure or Epilepsy				Manic/depression			
Migraine				ADHD/Hyperactivity			
Tuberculosis				Depression			
Hepatitis				Drug Use			