

**PEDIATRIC HEALTH HISTORY 11 to 21 years**

Patient's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Gender:  Male  Female

Previous Doctor: \_\_\_\_\_ City & State: \_\_\_\_\_

Reason for changing doctors \_\_\_\_\_

Person filling out this form \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Has your child ever had any of these problems? (please check)

- |                                                                         |                                                                   |
|-------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Problems seeing or hearing                     | <input type="checkbox"/> Pregnancy or caused a pregnancy          |
| <input type="checkbox"/> Mono                                           | <input type="checkbox"/> Sexually transmitted diseases            |
| <input type="checkbox"/> Strep throat                                   | <input type="checkbox"/> Migraines or other headaches             |
| <input type="checkbox"/> Allergies                                      | <input type="checkbox"/> Seizures                                 |
| <input type="checkbox"/> Asthma                                         | <input type="checkbox"/> Head injury                              |
| <input type="checkbox"/> Pneumonia                                      | <input type="checkbox"/> Other neurologic problems                |
| <input type="checkbox"/> Other breathing or respiratory problems _____  | <input type="checkbox"/> Broken bones                             |
| <input type="checkbox"/> Bladder/kidney infection                       | <input type="checkbox"/> Stitches                                 |
| <input type="checkbox"/> Other bladder/kidney problems _____            | <input type="checkbox"/> Poisoning                                |
| <input type="checkbox"/> Any stomach or digestive problems              | <input type="checkbox"/> Burns that needed a doctor's care        |
| <input type="checkbox"/> Any glandular problems (diabetes, thyroid etc) | <input type="checkbox"/> Attention deficit/hyperactivity disorder |
| <input type="checkbox"/> Heart murmur                                   | <input type="checkbox"/> Weight concerns (too much/too little)    |
| <input type="checkbox"/> Other heart problems _____                     | <input type="checkbox"/> Alcohol /drug use ( <i>ever</i> )        |
| <input type="checkbox"/> Sickle Cell Anemia                             | <input type="checkbox"/> Tobacco use ( <i>ever</i> )              |
| <input type="checkbox"/> Anemia                                         | <input type="checkbox"/> Any other conditions _____               |

Has your child ever spent the night in the hospital (other than birth)?  No If so, when and for what? \_\_\_\_\_

Has your child ever needed surgery?  No If so, when and for what? \_\_\_\_\_

Has your child ever needed to go to the Emergency Department?  No If so, when, and for what? \_\_\_\_\_

Has your child ever had an allergic reaction to food?  No  Yes

Food	Reaction	Do they require an Epi-Pen?	If so, when does the Epi-Pen expire?

What medications does your child take? (prescription and over-the-counter)

Medication	Dose	Reason for medication	When started

Has your child ever had an allergic reaction to a medication?  No If so, what medication, what was the reaction? \_\_\_\_\_

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Has your child ever been evaluated by any specialists or clinics other than their primary doctor? (e.g. psychologists, counselors, physical, occupational or speech therapists?)

Name	Location	Reason for visit	Date last seen

**PUBERTAL DEVELOPMENT**

Female:

- Have you started your periods (menses)?  No  Yes
- How old were you when your periods started? \_\_\_\_\_
- How often does your period come? \_\_\_\_\_
- How many days do you have your period (bleeding)? \_\_\_\_\_
- Do you have cramps with your period?  No  Yes
- Do you take any medication for cramps?  No  Yes If yes, what? \_\_\_\_\_
- Do you examine your breasts every month?  No  Yes

Male:

- Has your voice changed?  No  Yes When did you first notice this? \_\_\_\_\_
- Are you growing facial hair?  No  Yes When did you first notice this? \_\_\_\_\_
- Have your testicles enlarged?  No  Yes When did you first notice this? \_\_\_\_\_
- Have you had any "wet dreams"?  No  Yes
- Do you do a testicular exam at home?  No  Yes
- Do you have any concerns about your testicular exam?  No  Yes \_\_\_\_\_

**DEVELOPMENT**

- Current grade level: \_\_\_\_\_ Current school: \_\_\_\_\_
- Ever repeated a grade?  No  Yes Ever advanced a grade?  No  Yes
- Has your child had any difficulties in school (either socially or academically):  No  Yes \_\_\_\_\_

- 
- What kind of grade or evaluation does your child usually receive:  Excellent  Good  OK  Poor
  - How does your child feel about their grades?  Very pleased  Satisfied  Unsatisfied
  - How do you feel about your child's progress?  Very pleased  Satisfied  Unsatisfied
  - Do you have any concerns about your child's school progress?  No  Yes \_\_\_\_\_
- 

**FAMILY MEDICAL HISTORY**

If present, please note relationship to patient (e.g. Mother, Brother, Paternal Grandmother)

- |                                                                                   |                                                                                  |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> Asthma _____                                             | <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder _____          |
| <input type="checkbox"/> Allergies _____                                          | <input type="checkbox"/> Alcohol/drug abuse _____                                |
| <input type="checkbox"/> Diabetes Mellitus _____                                  | <input type="checkbox"/> Colitis (Crohn's or ulcerative colitis) _____           |
| <input type="checkbox"/> Thyroid problems _____                                   | <input type="checkbox"/> Irritable bowel syndrome _____                          |
| <input type="checkbox"/> Sickle cell anemia _____                                 | <input type="checkbox"/> Kidney stones _____                                     |
| <input type="checkbox"/> Other bleeding or blood disorders (please specify) _____ | <input type="checkbox"/> Other bladder or kidney problems (please specify) _____ |
| <input type="checkbox"/> Seizures _____                                           | <input type="checkbox"/> Cancer _____                                            |
| <input type="checkbox"/> Migraines _____                                          | <input type="checkbox"/> Heart attack before 50 years old _____                  |
| <input type="checkbox"/> Anxiety _____                                            | <input type="checkbox"/> Other heart problems (please specify) _____             |
| <input type="checkbox"/> Depression _____                                         | _____                                                                            |

**PEDIATRIC HEALTH HISTORY 11 to 21 years**

- High cholesterol \_\_\_\_\_
- Death of infant or young child \_\_\_\_\_
- Other medical problems (please specify) \_\_\_\_\_

**SOCIAL HISTORY**

Who lives with this child?:

Full Name:	Age:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child live in any other homes?  No  Yes

When do they live there? \_\_\_\_\_

Who lives with them at this home?

Full Name:	Age:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are parents married, unmarried or divorced? (please circle)

Does anyone smoke (inside or outside)?  No  Yes

(who): \_\_\_\_\_

We recommend that your child is NOT around any tobacco smoke. Exposure to tobacco smoke can increase your child's risk for "colds", ear infections, bronchitis and acute asthma attacks. It can increase a baby's risk of Sudden Infant Death Syndrome (SIDS).

What are parents' occupations?

Mother/partner: \_\_\_\_\_ Father/partner: \_\_\_\_\_

What kind of hobbies, extra-curricular activities or sports does your child participate in? \_\_\_\_\_

Is there anything else you would like us to know about your child? \_\_\_\_\_

For teenagers:

Do you have a job?  No  Yes Where? \_\_\_\_\_ How many hours/week? \_\_\_\_\_

Do you have a driver's license?  No  Yes

What are your future plans for life after high school? \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_