# 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)

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

☐ Asthma __________________________________
☐ Allergies __________________________________
☐ Diabetes Mellitus _________________________
☐ Thyroid problems _________________________
☐ Sickle cell anemia _________________________
☐ Other bleeding or blood disorders (please specify)__________________________________
☐ Seizures __________________________________
☐ Migraines ________________________________
☐ Anxiety __________________________________
☐ Depression ________________________________
☐ Attention Deficit/Hyperactivity Disorder ______
☐ Alcohol/drug abuse ________________________
☐ Colitis (Crohn's or ulcerative colitis) __________
☐ Irritable bowel syndrome___________________
☐ Kidney stones ____________________________
☐ Other bladder or kidney problems (please specify) _________________________________
☐ Cancer ___________________________________
☐ Heart attack before 50 years old ____________
☐ Other heart problems (please specify)________
_____________________________________________

**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?

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: _________________________