New Patient Health History - Pediatric 6-17 years

Name _____ **Date of Birth** _____ **Today's Date** _____

Current Medical Concerns (what you would like to talk about today):

_____

_____

Please list any allergies you have to medications:
NAME OF MED Reaction

_____

_____

Please list any medications you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:
NAME OF MED Dose Directions (How often given)

_____

_____

Immunizations
Do you follow the recommended CDC vaccination schedule? ❒ Yes ❒ No

Please explain if altering schedule:_____

Any hospitalizations? ❒ Yes ❒ No If yes, please explain below:

_____

_____

Please circle any surgeries: ❒ Heart ❒ Ear Tubes ❒ Tonsils/Adenoids ❒ Appendix ❒ Circumcision ❒ Frenulectomy (tongue clipping) ❒ Eye Surgery ❒ Hernia Repair, type: _____ ❒ Other:_____

For ages 12-17 only Who is filling out this portion of the form?

_____ Sexually Active? ❒ Yes ❒ No If Yes, number of total partners (past and present):_____ If YES, do you use condoms always? ❒ Yes ❒ No

Do you use another form of Birth Control or Contraception? ❒ Yes ❒ No

Menstrual Periods started at age _____ Date of Last Menstrual Period

_____ Any past pregnancies? ❒ Yes ❒ No

FAMILY HEALTH HISTORY

Are you adopted? ❒ Yes ❒ No (If NO, please complete section below) P=Paternal M=Maternal

	Mother	Father	Grandma	Grandpa	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism/Substance Abuse								
Aneurysm								
Anxiety and/or Depression								
Arthritis								
Asthma								
Bipolar or Schizophrenia								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Seizures/Epilepsy								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

PERSONAL HEALTH HISTORY

ADHD or ADD	❒ Yes	❒ No	Endometriosis	❒ Yes	❒ No
Alcoholism/Substance Abuse	❒ Yes	❒ No	Fibromyalgia	❒ Yes	❒ No
Allergies/Hay fever	❒ Yes	❒ No	Gout	❒ Yes	❒ No
Anemia	❒ Yes	❒ No	GYN Problems	❒ Yes	❒ No
Anesthesia Complications	❒ Yes	❒ No	HIV	❒ Yes	❒ No
Anxiety Disorder or Recurrent Anxiety	❒ Yes	❒ No	Heart Problems	❒ Yes	❒ No
Arthritis	❒ Yes	❒ No	Hepatitis C	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	High Blood Pressure/Hypertension	❒ Yes	❒ No
Autism Spectrum Disorder	❒ Yes	❒ No	High Cholesterol	❒ Yes	❒ No
Bipolar or Schizophrenia	❒ Yes	❒ No	Kidney Stones	❒ Yes	❒ No
Birth Defects or Inherited Disease	❒ Yes	❒ No	Kidney or Bladder Problems	❒ Yes	❒ No
Blood Transfusion	❒ Yes	❒ No	Liver Disease	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Migraines	❒ Yes	❒ No
Chicken Pox	❒ Yes	❒ No	Muscle, Joint, or Bone Problems	❒ Yes	❒ No
Clotting Problems/bleed too much	❒ Yes	❒ No	Osteoporosis	❒ Yes	❒ No
Depression	❒ Yes	❒ No	Reflux/GERD	❒ Yes	❒ No
Developmental or Behavioral Disorders	❒ Yes	❒ No	Seizures/Epilepsy	❒ Yes	❒ No
Diabetes or Pre-Diabetes	❒ Yes	❒ No	Skin problems (Rashes/Changing Moles)	❒ Yes	❒ No
Diverticulitis/Diverticulosis	❒ Yes	❒ No	Stomach Ulcers or Swallowing Problems	❒ Yes	❒ No
Domestic Violence	❒ Yes	❒ No	Stroke or TIA	❒ Yes	❒ No
Ear Infections - Chronic	❒ Yes	❒ No	Thyroid Problems	❒ Yes	❒ No
Ear or Hearing Problems	❒ Yes	❒ No	Tuberculosis or Positive TB Test	❒ Yes	❒ No
Eating Disorder like Anorexia or Bulimia	❒ Yes	❒ No	Vision or Eye Problems	❒ Yes	❒ No
Eczema	❒ Yes	❒ No	Other:	❒ Yes	❒ No
Emphysema/COPD/Chronic Bronchitis	❒ Yes	❒ No			