Pediatric / Adolescent Health History

Patient's Name: _____ **Date of Birth:** _____ **Age:** _____ **Male / Female**

Current Medical Provider: _____ Reason for transfering care: _____

CURRENT HEALTH

Present Health Concerns: _____

MEDICATIONS: Please list ALL medications including Vitamins, herbs, home remedies

Medication Name	Strength (mg)	Directions	Reason Taking

ALLERGIES: or reactions to Medications, environmental, animals, food, vaccines, etc.

Allergy	Symptoms or reaction

DENTAL: Has child been seen by a dentist? ☐ Yes ☐ No If yes, date of last visit: _____

Name of dental provider: _____ How often seen: _____

Has child had dental sealants: ☐ Yes ☐ No ☐ Unsure If yes, when: _____

IMMUNIZATIONS: **Please bring your child's immunization records with you** (*If received outside of Oregon*)

Up to date? ☐ Yes ☐ No ☐ Unsure Reactions to past vaccines (*if any*): _____

ADOLESCENT HEALTH QUESTIONNAIRE (***for ages 12 and older***) Please have the **PATIENT** answer the questions

Do you use tobacco or nicotine? ☐ Yes ☐ No ☐ Previously What type: _____

*In the **last 12 months**, did you:*

Drink any alcohol (more than a few sips)?	☐ No	☐ Yes
Smoke any marijuana or hashish?	☐ No	☐ Yes
Use anything else to get high?	☐ No	☐ Yes

*Have or do you **EVER**:*

Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐ No	☐ Yes
Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	☐ No	☐ Yes
Do you ever use alcohol or drugs while you are by yourself or alone?	☐ No	☐ Yes
Do you ever forget things you did while using alcohol or drugs?	☐ No	☐ Yes
Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐ No	☐ Yes
Have you ever gotten into trouble while you were using alcohol or drugs?	☐ No	☐ Yes

During the past 2 weeks, have you been bothered by little interest or pleasure in doing things?	☐ No	☐ Yes
During the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?	☐ No	☐ Yes

Patient's Name: _____ Date of Birth: _____

MEDICAL HISTORY

Please describe any major medical problems (Asthma, Seizures, Heart Problems, Diabetes, etc):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hospitalizations / Surgeries (include year):

_____ _____ _____

_____ _____ _____

Broken Bones or Severe Sprains (include area of body):

_____ _____ _____

Female Patients: (*If applicable*)

Age menstrual period started:_____ First day of last period: _____

Are you sexually active? ☐ Yes ☐ No ☐ Never Contraceptive history: _____

Infectious Diseases: Has your child had any of the following:

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis

☐ Pertussis (whooping cough) ☐ Other _____

PREGNANCY AND BIRTH

Where was your child born:_____

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____

Birth Weight: _____ Length: _____ Premature: ☐ No ☐ Yes If so, how early: _____

Delivered by: ☐ Vaginal birth ☐ Ceasarean If Ceasarean, why? _____

Medical problems during pregnancy: _____

Medical problems during child's newborn period: _____

FAMILY / SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship

Child's School: _____ Grade: _____

Are there any pets in the home? ☐ Yes ☐ No If yes, list: _____

Does anyone in the home smoke? ☐ Yes ☐ No Who? _____ ☐ Inside ☐ Outside ☐ Car

Please list any sports played or hobbies: _____

Patient's Name: _____ Date of Birth: _____

FAMILY HEALTH HISTORY

Please indicate with an **X** family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Angina												
Arthritis												
Anxiety												
Asthma												
Birth Defects												
Bleeding Disease												
Breast Cancer												
Cervical Cancer												
Coronary Heart Disease												
Colon Cancer												
Depression												
Diabetes												
Growth / Development Disorder												
Headaches												
Heart Disease												
Hypertension												
High Cholesterol												
Kidney Disease												
Lung Cancer												
Lung / Respiratory Disease												
Melanoma / Skin Cancer												
Migraines												
Osteoporosis												
Ovarian Cancer												
Psychiatric Care												
Seizures												
Severe Allergies												
Stroke												
Thyroid Problems												
Uterine Cancer												
Weight Disorder												
Other Cancer												
Other Medical Problems												
No / Unknown Family History												

For office use only

Reviewed by Provider: _____ **Date:** _____