Please provide us with your child's complete medical and social history. Make sure to fill out ALL 3 SIDES.

For Teens 14-years and older:

Patient Name ________________________ Date of Birth _____ / _____ / _____ Cell #: (   ) _____ - _________

Patient's Past Medical History: CHECK HERE IF THE PATIENT HAS NONE OF THE CONDITIONS BELOW

Acne
ADHD
Anaphylaxis
Anemia
Anxiety
Arthritis
Asthma
Autism
Birth Asphyxia
Birth Trauma
Birthmark
Bladder Reflux
Bronchiolitis
Bronchitis
Cancer
Cataract
Celiac Disease
Chickenpox
Cleft Lip
Cleft Palate
Cognitive Deficit
Concussion
Crohn's Disease
Depression
Diabetes
Eczema
Emotional Problems
Endocrine Disorder
Food Allergy
GI Disorder
GI Reflux
Head Injury
Hearing Deficit
Heart Disease
Heart Murmur
Hematologic Disorder
Hernia, Inguinal
Hernia, Umbilical
Hydrocephalus
Hyperthyroidism
Hypospadias
Hypothyroidism
Irritable Bowel
Jaundice
Kidney Disease
Kidney Stone
Lung Disease
Meningitis
Migraine
Mononucleosis
Nephrotic Syndrome
Obesity
Palpitations
Pneumonia
Premature Birth
Respiratory Distress Syndrome
Respiratory Problem
Scoliosis
Seasonal Allergies
Seizure Disorder
Serious Injury
Skin Disease
Smoking
Stroke
Substance Abuse
Ulcerative Colitis
Urinary Tract Infection
Vision Deficit

Other Disorder or Condition:____

Patient's Past Surgical History: CHECK HERE IF THE PATIENT HAS NEVER HAD SURGERY

Adenoidectomy
Appendectomy
Circumcision
Cleft Lip Repair
Cleft Palate Repair
Colonoscopy
Congenital Heart Problem Repair
Ear Tube Placement
Endoscopy
Hydrocele Excision
Inguinal Hernia Repair
Mass Excision
Naso-lacrimal Duct Probing
Nevus Excision
Orchiopexy
Orthopedic Surgery
Pilonidal Sinus Surgery
Plastic Surgery
Pre-auricular Sinus Excision
Rhinoplasty
Scoliosis Surgery
Sinus Surgery
Strabismus Repair
Thyroglossal Duct Cyst
Tonsillectomy
Tonsillectomy & Adenoidectomy
Umbilical Hernia Repair
Ureteral Re-implantation
Varicocele Excision
Ventriculo-Peritoneal Shunt for Hydrocephalus

Other Surgery or Procedure: ____

Patient's Current Medications: CHECK HERE IF THE PATIENT TAKES NO DAILY MEDICATIONS

Daily Medications: ____

Patient's Allergies: CHECK HERE IF THE PATIENT HAS NO ALLERGIES TO MEDICATIONS

Medication Allergies: ____

CHECK HERE IF THE PATIENT HAS NO OTHER ALLERGIES

Other Allergies (environmental, food, etc): ____

OVER

Family Medical History: Please indicate who has each disease and age of onset

CHECK HERE IF THE PATIENT'S **FAMILY** HAS NO CHRONIC MEDICAL PROBLEMS

Allergies: ____________________
Alcohol Abuse: ____________________
Anemia: ____________________
Arthritis: ____________________
Asthma: ____________________
Birth Defect: ____________________
Cancer: ____________________
Coagulation Abnormality: ____________________
Cognitive Deficit: ____________________
Coronary Atherosclerosis: ____________________
Depression: ____________________
Diabetes: ____________________
Hearing Deficit: ____________________
Heart Disease: ____________________
High Blood Pressure: ____________________
High Cholesterol: ____________________
Hyperthyroidism: ____________________
Hypothyroidism: ____________________
Illegal Drug Use: ____________________
Infections: ____________________
Kidney Disease: ____________________
Lung Disease: ____________________
Mental Health Disorder: ____________________
Mental Retardation: ____________________
Migraine: ____________________
Obesity: ____________________
Prescription Drug Abuse: ____________________
Scoliosis: ____________________
Seizures: ____________________
Stroke: ____________________
Substance Abuse: ____________________
Sudden Infant Death Syndrome: ____________________
Vision Deficit: ____________________
Other Chronic Medical Condition: ____________________

Patient's Pre-Natal History:

Hospital Of Birth: ________________ Mother's Age at Patient's Birth: ______ Type Of Delivery: Vaginal C-Section

Mother's Medical Problems During Pregnancy: ____________________

During the Pregnancy did Mom (circle all that apply): Smoke/Drink Alcohol/Illicit Drugs/Prescription Meds/X-rays?

Patient's Gestational Age at Birth: Full Term (37wks +) Premature: ____ weeks

Problems During Labor or Delivery: ________________ Problems in the Newborn Nursery: ________________

Patient's Social History:

Does anyone in the Patient's home smoke? No Yes: Who smokes? ________________

Parent (Mother/Father) Occupation: ____________ Parent (Mother/Father) Occupation: ________________

Family Structure (Check all that apply): Adopted Parents are married

Parents are not married Parents are separated Parents are divorced

Who does the patient primarily live with? Mom Dad Other: ________________

Father is not involved Mother is not involved Father is deceased Mother is deceased

Number Sisters: ______ Number of Brothers: ______ Number of people living at home: ______

History of Abuse: No Yes: Check all that apply: Emotional abuse Physical abuse Sexual abuse

Identify individuals who provide **family support** (Check all that apply): Babysitter Grandparent Other: ___________

Any concerns related to Poverty, Homelessness, Unemployment, or Incarceration? No Yes: Explain: _____________

Is anyone in the family Homosexual, Bisexual, or Transgender? No Yes: Explain: ____________________

Patient's Specialists, Emergency Room Visits, and Hospital Visits:

Please list all Doctors and Therapists who the patient has seen, and all Emergency Room visits and Hospital admissions:

Specialist Type: (ie Endocrinologist)	Specialist Name: (ie Dr. Smith)	Condition being Managed (ie Diabetes)
1. ______________	______________	______________
2. ______________	______________	______________
ER Visit: Hospital Name:	**Date:**	**Condition Treated:**
1. ______________	______________	______________

Thank you for helping us keep your child's medical and social histories current.

2. ______________________ ______________________ ______________________

Admission: Hospital Name:	Date:	Condition Treated:
1.		
2.		

Patient's Review of Systems:

Please check any symptom that has been a frequent or severe problem for the patient.

CHECK IF THE PATIENT HAS NOT HAD ANY OF THE FOLLOWING SYMPTOMS

Constitutional:

Body aches	Fatigue	Excess weight gain	Night Sweats
Chills	Fever	Excessive sleep	Poor weight gain
Difficulty sleeping	Frequent illness	Loss of appetite	Unexpected weight loss

Eyes:

Blurred Vision	Eye Discharge	Eye pain	Lazy eye

Head, Ears, Nose, Throat:

Dental problems	Ear pain	Nasal congestion	Snoring
Difficulty hearing	Fluid in ears	Nose bleeds	Sore throat
Ear infections	Hoarseness	Sinus infections	Swollen glands

Breasts:

Abnormal changes in breast size	Lumps
Breast discharge	Tenderness

Cardiovascular:

Chest pain	Irregular heart beat	Poor exercise tolerance
Fainting	Leg swelling	Rapid heart rate

Respiratory:

Coughing	Shortness of breath	Wheezing
Difficulty breathing	Sleep apnea	

Gastrointestinal:

Abdominal pain	Excessive belching	Jaundice	Strains to move bowels
Bloating	Excessive gas	Mucus in stool	Trouble swallowing
Blood in stool	Fecal incontinence	Nausea	Vomiting
Constipation	Heartburn	Poor feeding	
Diarrhea	Hemorrhoids	Reflux	

Genitourinary:

Bleeding between periods	Frequent periods	Irregular periods	Toilet training difficulty
Blood in urine	Frequent urination	Painful periods	Very heavy periods
Change in urine color	Genital discharge	Painful urinations	
Delayed onset of menses	Genital sores	Scrotal mass	
Difficulty urinating	Incontinence	Scrotal pain	

Skin:

Acne	Hair growth change	Itching	Pigmentation changes
Changing skin lesion or mole	Hair loss	New skin lesions	Rash

Neurologic:

Developmental delay	Loss balance	Poor coordination	Tingling or numbness
Dizziness	Memory difficulties	Seizures	Tremors
Head injury	Muscle weakness	Speech difficulty	Unusual movement
Headaches	Poor eye contact	Stuttering	

Musculoskeletal:

Back pain	Joint swelling	Limitation of motion	Muscle pain
Joint pain	Limb pain	Limp	

Endocrine:

Cold intolerance	Excess body hair	Excess urinating	Heat intolerance
Delayed sexual development	Excess drinking	Hair loss	Premature sexual development

Psychiatric:

Anxiety	Difficulty sleeping	Impulsive behavior	Separation problems
Compulsive behavior	Excessive anger	Inattentiveness	Suicidal ideation
Delusions	Hallucinations	Poor school performance	Temper tantrums
Depression	Hyperactivity	Poor social integration	

Heme-Lymph:

Easy bleeding or bruising	Pallor	Swollen glands

Allergic-Immunologic:

Allergic Symptoms	Seasonal Allergies	Food Allergies

Substance Use History:

HAS NEVER SMOKED	Cigarette smoking	Smokeless tobacco	E-cigs

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Marijuana Other illicit drugs Alcohol

Details of checked symptoms and/or additional symptoms: ____

____

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