

Pediatric Medical History Update (13-17 years)

Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Person completing form \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Reason for visit today \_\_\_\_\_

\_\_\_\_\_

List all medicines, vitamins, and over the counter medicine patient takes currently

\_\_\_\_\_

\_\_\_\_\_

New allergies to medicine or food \_\_\_\_\_

What kind of milk does child drink (whole, skim, soy, etc.) \_\_\_\_\_ Cups per day \_\_\_\_\_

If child drinks juice, how many ounces per day \_\_\_\_\_ Servings of fruit per day \_\_\_\_\_

Servings of vegetables per day \_\_\_\_\_ If child eats meat, servings per day \_\_\_\_\_

Concerns about eating habits? \_\_\_\_\_

Number of hours child sleeps at night \_\_\_\_\_ Sleeping problems? \_\_\_\_\_

How often are dental visits? \_\_\_\_\_ Any dental problems? \_\_\_\_\_

How many hours per day does your child watch TV? \_\_\_\_ Use computer? \_\_\_\_ Video games \_\_\_\_\_

Cell phone \_\_\_\_\_

Any updates to family history? Please indicate which family member has had the following since your child's last visit: Alcohol or drug abuse \_\_\_\_\_ Cancer \_\_\_\_\_

Kidney disease \_\_\_\_\_ Heart disease \_\_\_\_\_ Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_

High blood pressure \_\_\_\_\_ ADHD or ADD \_\_\_\_\_ Seizures \_\_\_\_\_

Thyroid problem \_\_\_\_\_ Psychiatric problem \_\_\_\_\_ Asthma or eczema \_\_\_\_\_

Other \_\_\_\_\_

Who lives in household with child?

Name	Age	Relationship to child
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are parents of child: Married Partnered Separated Divorced

Who has custody of child \_\_\_\_\_ Child care situation \_\_\_\_\_

Mother's occupation \_\_\_\_\_ Father's occupation \_\_\_\_\_

Any concerns about violence in the home? \_\_\_\_\_ Guns in home? \_\_\_\_\_ If so, are they safely stored? \_\_\_\_\_

Name of school \_\_\_\_\_ Grade \_\_\_\_\_

Any concerns about: School behavior \_\_\_\_\_

Home behavior \_\_\_\_\_

School performance \_\_\_\_\_

Relationships with teachers \_\_\_\_\_ With peers \_\_\_\_\_

Does child play sports or do regular exercise? \_\_\_\_\_ Which type? \_\_\_\_\_

How many days a week? \_\_\_\_\_ For how long \_\_\_\_\_

Does child ride a bike? \_\_\_\_\_ If so, does child ride a bike helmet? \_\_\_\_\_

Does child use seat belt consistently? \_\_\_\_\_ Wear sunscreen when appropriate? \_\_\_\_\_

Any smokers in the house or car? \_\_\_\_\_

Does your child have any of the following?

Fever, chills, excess sweating \_\_\_\_\_ Unexplained lumps \_\_\_\_\_

Unexplained weight loss or gain \_\_\_\_\_ Easy bruising or bleeding \_\_\_\_\_

Vision problems \_\_\_\_\_ Hearing problems \_\_\_\_\_

Headaches \_\_\_\_\_ Hay fever, allergies \_\_\_\_\_

Weakness, clumsiness \_\_\_\_\_ Mouth breathing, snoring \_\_\_\_\_

Muscle or joint pain \_\_\_\_\_ Runny nose, cough \_\_\_\_\_

Rash, unusual moles \_\_\_\_\_ Acne \_\_\_\_\_

Anxiety, stress, depression \_\_\_\_\_

(Girls) Problem with periods \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Health provider review \_\_\_\_\_ Date \_\_\_\_\_

