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

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 _____