Complete Pediatric Medical History (13-17 Years)

Patient's Name_____ **Sex**_____ **Date of Birth**_____

Person completing form_____ Relationship to patient_____

Reason for visit today _____

List all medicines, vitamins, over the counter medicines taken _____

_____

_____

Hospitalizations and dates _____

Surgery and dates _____

Injuries and dates _____

Chronic illness (asthma, ADHD, anxiety, depression, etc.) _____

_____

Allergies to any medicines or food _____

Where was child born? _____ Medical problems in pregnancy? _____

Medical problems in infancy? _____

Is the child yours by: Birth Adoption Foster Step-child Guardianship

Are the parents of the child: Married Partnered Separated Divorced

Who has custody? _____

Nutrition:

What kind of milk goes the child drink (whole, skim, soy, etc.)?_____Cups per day_____

What kind of water does child drink (tap, bottled, well)? _____If child drinks juice, how many cups per day? _____ Servings of fruit per day _____ Servings of vegetables per day_____

If child eats meat, servings per day _____ Any concerns about eating habits?_____

_____

How many hours of sleep does child typically get? _____ Sleeping difficulty? _____

Dental:

When was the last dental check? _____ How often are dental visits? _____

Any dental problems? _____

Girls: If periods have started, at what age _____ How often? _____ How many days? _____

Any problems with periods? _____

Infectious Disease: If child has had any of the following, please give dates: Chicken pox _____

Measles _____ Mumps _____ Rubella _____ Meningitis _____ Tuberculosis _____

Exposures/Habits: Has child been exposed to: Lead Smoke Marijuana Other drugs Abuse

How many hours per day does child watch TV_____ Use computer_____ Video games_____

Cell phone_____

Family History: (please indicate which family members have the following conditions)

Alcoholism/drug use _____ High blood pressure _____

Cancer, and what type _____ Seizures _____

Kidney disease _____ Thyroid Disease _____

Diabetes _____ Heart disease _____

Stroke _____ Asthma/eczema _____

ADHD _____ Psychiatric disorders _____

Bleeding/clotting disorders _____

Social History: Who lives at home with child?

Name	**Age**	**Relationship**

Mother's occupation _____ Father's occupation _____

Is violence a concern in the home? _____ Are there guns in the home? _____

If so, are they safely stored? _____

Is child home schooled? _____ If not, name of school_____
Grade _____

Concerns about school performance? _____

Concerns about school behavior? _____

Concerns about relationships with teachers? _____ with peers? _____

Does child play sport or do regular exercise? _____ Which type? _____

How many days a week? _____For how long? _____ Does child ride a bike? _____

If so, does child wear bike helmet? _____ Does child wear seatbelt consistently? _____

Use sunscreen when appropriate? _____ Any smokers in the house or car? _____

Any concerns about alcohol use? _____ Drug use? _____ Sexual activity? _____

Smoking? _____ Bullying? _____

Symptoms: Please indicate if child is experiencing any of the following:

Fever, chills, excess sweating _____Headaches _____

Unexplained weight loss/gain _____ Weakness, clumsiness _____

Vision problem _____ Hearing problem _____ Speech problem _____

Muscle or joint pain _____ Allergies, hay fever _____

Acne_____ Rashes _____ Unusual moles _____

Cough or wheeze _____ Short of breath _____

Constipation _____ Diarrhea _____Nausea, vomiting _____

Blood in stool _____ Fainting _____ Tires easily with exertion _____

Anxiety, stress, depression _____

Comments: Do you have any other comments or concerns? Please share any additional information you feel would be helpful for the health care provider to best meet your child's needs.

_____

_____

_____

_____

_____

Parent/guardian signature _____ Date _____

Health care provider reviewed _____ Date _____