

**New Patient Health History - Pediatric 6-17 years**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Current Medical Concerns** (what you would like to talk about today):

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**Please list any allergies you have to medications:**

NAME OF MED Reaction

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**Please list any medications you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:**

NAME OF MED Dose Directions (How often given)

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**Immunizations**

Do you follow the recommended CDC vaccination schedule?  Yes  No

Please explain if altering schedule: \_\_\_\_\_

**Any hospitalizations?**  Yes  No If yes, please explain below:

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**Please circle any surgeries:**  Heart  Ear Tubes  Tonsils/Adenoids  Appendix  Circumcision  Frenulectomy (tongue clipping)  Eye Surgery  Hernia Repair, type: \_\_\_\_\_  Other: \_\_\_\_\_

**\*For ages 12-17 only\*** Who is filling out this portion of the form?  
\_\_\_\_\_  
Sexually Active?  Yes  No If Yes, number of total partners  
(past and present): \_\_\_\_\_ If YES, do you use condoms always?  Yes  No  
Do you use another form of Birth Control or Contraception?  Yes  No  
Menstrual Periods started at age \_\_\_\_\_ Date of Last Menstrual Period  
\_\_\_\_\_ Any past pregnancies?  Yes  No

Do you or have you ever smoked tobacco?  Yes  No

How Many Years did you smoke tobacco? \_\_\_\_

Do you use or have you used other forms of tobacco, like chewing tobacco?  Yes  No

Do you use e-cigarettes (vape)?  Yes  No

## FAMILY HEALTH HISTORY

Are you adopted?  Yes  No (If NO, please complete section below) P=Paternal M=Maternal

	Mother	Father	Grandma	Grandpa	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism								
Aneurysm								
Anxiety								
Arthritis								
Asthma								
Bipolar Disorder								
Cancer								
Depression								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Schizophrenia								
Seizures/Epilepsy								
Skin Cancer								
Stroke								
Substance Abuse								
Sudden Cardiac Death								
Thyroid Disorder								

## PERSONAL HEALTH HISTORY

ADHD or ADD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism/Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies/Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	GYN Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anesthesia Complications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety Disorder or Recurrent Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure/Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bipolar or Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birth Defects or Inherited Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney or Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle, Joint, or Bone Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clotting Problems/bleed too much	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reflux/GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Developmental or Behavioral Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes or Pre-Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin problems (Rashes/Changing Moles)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diverticulitis/Diverticulosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Ulcers or Swallowing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Domestic Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke or TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear Infections - Chronic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear or Hearing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis or Positive TB Test	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder like Anorexia or Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision or Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema/COPD/Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			