Pediatric and Adolescent Medicine
Annual Health History Update

Today's Date: ___/___/____
Primary pediatrician: _____

Patient's Full Name:_____ ☐ male ☐ female ☐ other
Birth Date: ___/___/___ Preferred Pronouns:_____
Name of person completing this form:_____ Relationship to patient:_____

Please list patient's current medical diagnoses: ☐None

Please list all medicines/vitamins/supplements: ☐None

Please list any medicine/food/latex allergies: ☐None

Since the last check up: my CHILD has: *(Include details)*

-been in a hospital overnight? ☐Y

-gone to the emergency room? ☐Y

-gone to an urgent care center? ☐Y

-had an allergic reaction? (medication, food, insect) ☐Y

-had surgery? (an operation) ☐Y

-seen a medical specialist or doctor elsewhere? ☐Y

-traveled outside of the U.S.? ☐Y

Today I have concerns about:

Headaches/Head Injury?..... ☐Y
Vision/Hearing?..... ☐Y
Dental? ..... *(Brushes?* ☐Y ☐ N*, Sees dentist?*☐Y☐ N*)* .....☐Y
Ears/Eyes/Nose/Throat? ..... ☐Y
Allergies?..... ☐Y
Cough/Wheeze/Trouble breathing? ..... ☐Y
Chest pain?..... ☐Y
Abdominal pain?..... ☐Y
Stools or Urination?..... ☐Y
Genitals?..... ☐Y
Muscles/Joints/Bones?..... ☐Y
Skin?..... ☐Y
Abnormal Bleeding or Bruising?..... ☐Y
Sleep?...*(at least 10-12h preschool, 10h 5-12y, 9-10h teens)*..... ☐Y
Development?..... ☐Y
Behavior/Mental Health?..... ☐Y
Learning/School Performance?..... ☐Y
Nutrition?..... ☐Y
Weight/Growth?..... ☐Y
Substance use/abuse?..... ☐Y
Sexual activity?..... ☐Y
Other? *(Include details)*..... ☐Y

For girls: Has she started her period? ☐N ☐Y, at age _____
If yes, when did the last period start? ___/___/___
Is she having any problems? ☐N ☐Y:

	Parent/Guardian #1	Parent/Guardian #2
Name:		
Preferred contact #:		
Occupation:		

Parents are: ☐Married ☐Divorced ☐Separated ☐Single ☐Other:
Child lives with: ☐Both parents ☐Other: _____
☐Parent #1_____% (☐*remarried*) ☐Parent #2_____% (☐*remarried*)
Others in the home: *(name/age/relationship)*

Recent family changes or stress? ☐ N ☐Y:
Patient attends:
☐**Daycare** ☐Sitter ____ days/week at _____
☐**Preschool** ____ days/week at _____
☐**School**, in Grade:____ at _____
---Child's school performance/grades/GPA: _____
Does your child receive any special services? ☐N ☐Y
☐IEP ☐504 ☐Gifted ☐Therapy ☐Other:

Patient's sports/activities/hobbies:

Concerns about relationships w/ friends, family, others? ☐N ☐Y

Home Environment/Safety: What year was your home built? _____
☐House ☐Apartment ☐Condo ☐Trailer ☐Other:
Are there: Carbon monoxide detectors? ☐Y
----------Smoke detectors? ☐Y
----------Fire extinguishers? ☐Y
----------Pool? ☐Y Locked? _____How? _____
--Pets/Animals? ☐Y What kind? _____
---------Firearms? ☐Y How are they stored?_____
-- ------Smokers? ☐Y Who smokes? _____ Where? _____

Does your child: -wear a helmet appropriately? ☐Y
-use sunscreen appropriately *(SPF 15 or above)*? ☐Y
-know how to swim *(or take lessons if 4 or older)*? ☐Y

When riding in a car, my child uses:
☐Rear-facing car seat *(<2y)*
☐Front-facing car seat *(until weight exceeds seat specifications)*
☐Booster *(belt positioning booster seat until 4'9")*
☐Seat Belt in back seat ☐Seat belt in front seat *(>12y)*

(Please complete other side) updated 6/14/2022

Patient Name: _____ DOB: _____/_____/_____ Today's Date: _____/_____/_____

Please record your child's Family Medical History below:

☐ I have multiple children here TODAY and have completed this TODAY on the form of child: _____

☐ Patient adopted; No **Biologic** Family History available.

☐ Patient adopted; Limited **Biologic** Family History recorded below.

☐ Patient conceived by IVF with donor ☐Egg ☐Sperm (only include details of blood relatives below)

Have any blood relatives of THIS PATIENT had these conditions? (parents, siblings, grandparents, aunts, uncles)

-**Please include details for all YES answers including which relatives and whether on father's or mother's side.**

ADD/ADHD……☐ Y:

Alcoholism ……☐ Y:

Allergies……☐ Y:

Asthma……☐ Y:

Birth Defects ……☐ Y:

Blood/Bleeding disorders……☐ Y:

Bowel Disease……☐ Y:

(Ulcerative colitis, Crohn's, Irritable Bowel)

Cancer (*include type*) ……☐ Y:

Deafness……☐ Y:

Depression……☐ Y:

Developmental delays……☐ Y:

Diabetes (*Type 1 or Type 2?*)……☐ Y:

Early death/SIDS……☐ Y:

Eczema……☐ Y:

Family or inherited diseases……☐ Y:

Heart attack before age 55……☐ Y:

Heart disease……☐ Y:

High cholesterol/lipids/triglycerides……☐ Y:

High blood pressure……☐ Y:

Hip dysplasia……☐ Y:

Immune disorders……☐ Y:

Intellectual Disability……☐ Y:

Kidney Disease……☐ Y:

Learning Disability……☐ Y:

Liver Disease……☐ Y:

Lung Disease……☐ Y:

Mental Health *(Anxiety, Bipolar, Depression, etc.)* .☐ Y:

Metabolic Disorders……☐ Y:

Migraines……☐ Y:

Neurologic disease……☐ Y:

Obesity……☐ Y:

Scoliosis……☐ Y:

Seizures/Epilepsy……☐ Y:

Serious or fatal childhood illness……☐ Y:

Strabismus ("Lazy eye") ……☐ Y:

Substance abuse……☐ Y:

Thyroid disease……☐ Y:

Tuberculosis……☐ Y:

Other……☐ Y:

Thank you for completing this information.