Name: _____ Date: _____

Main Reason for Today's Visit: _____

Birth History:

Born at _____ in _____at _____ weeks gestation via Vaginal / C-Section.
(facility) (city, state)

PM**H:** (Indicate approximate year of diagnosis, and include important details below)

_____ Migraines	_____ High Cholesterol	_____ Arthritis
_____ Stroke	_____ Asthma/COPD	_____ Blood Disorder (explain)
_____ Eye Problems (explain)	_____ Liver Disease (explain)	_____ Skin Disorder (explain)
_____ Allergies (seasonal)	_____ Kidney Disease (explain)	_____ Anxiety/Depression
_____ Heart Disease (explain)	_____ Diabetes	_____ Cancer
_____ High Blood Pressure	_____ Thyroid Disease (explain)	_____ Trauma
_____ Acid Reflux	_____ Birth Complications	_____

(Explanation/Other) _____

_____

_____

Past Surgical History: (Surgery/Year/Dr. or Hospital)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

Who all lives in the home with the child? _____

Does anyone in the child's household Smoke Cigarettes, Cigars, Pipe, or us smokeless tobacco? YES NO

Does anyone in the household drink alcohol? YES NO If yes to either, what is his/her relationship to the child? _____

Has the child been Hospitalized in the last year? If Yes, Explain: _____

_____

FAMILY Medical History: List only first or second degree relatives (Indicate which family member for each with abbreviations)

F=Father, M=Mother, B=Brother, S=Sister, PGF=Paternal Grandfather, MGM=Maternal Grandmother, A=Aunt, U=Uncle, C=Child

_____ Migraines	_____ High Cholesterol	_____ Arthritis
_____ Stroke	_____ Asthma/COPD	_____ Blood Disorder
_____ Eye Problems (explain)	_____ Liver Disease	_____ Skin Disorder
_____ Allergies (seasonal)	_____ Kidney Disease	_____ Anxiety/Depression
_____ Heart Disease (explain)	_____ Diabetes	_____ Cancer
_____ High Blood Pressure	_____ Thyroid Disease	_____ Trauma

(Explanation/Other) _____

_____

Allergies: (List Specific Medication, Drug, or Food/Year of Last Event/Type of Reaction)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: Complete below or provide a separate list (Med/Year Started/Recent Prescribing Physician)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Systems: Please CIRCLE only if you are currently or recently had these symptoms, or they tend to recur often

Constitutional: Fever, Chills, Night Sweats, Unintentional Weight Loss

Eyes: Blurry Vision, Blind Spots in Vision

ENT: Runny Nose, Sinus Congestion, Sore Throat, Difficulty Swallowing

CV: Chest Pain, Racing Heart Beat, Lightheadedness, Leg Swelling, Short of Breath when Lay Flat

Resp: Shortness of Breath (at rest of with minimal exertion), Chronic Cough (> 3 weeks), Coughing Blood

GI: Heartburn, Abdominal Pain, Change in stool size or color, Blood in Stool

GU: Pain or Burning with Urination, Urinating More Often, Loss of Control, Weak Stream, Blood in Urine

MSK: Recent trauma, Muscle aches, Joint/Bone Pain, Muscle Twitching

Neuro: Numbness/Tingling, Weakness, Change in Gait, Dizziness

Skin: Rash, Ulcer, Non Healing Wound, New Lumps or Bumps, New or Changing Moles

Endocrine: Fatigue, Hair Loss, Dry Skin, Drinking more than normal, Urinating more than normal

Heme/Lymph: Easy Bruising, Nosebleeds, Enlarged Lymph Nodes

Allergy/Immune: Lip Swelling, Throat Closing Up, Recurrent Illnesses

Psych: Feeling Tearful, Anxious, Depressed, Seeing or Hearing things that are not there

Health Maintenance:

Is the child up to date on all Vaccines? _____ Please provide record if you have it.

When was the last time the child received a flu shot? _____

When was the last time the child had a wellness visit?_____

When was the last time , if ever, the child had any bloodwork done? _____

If female, has child begun having menstrual periods?_____. If yes, at what age? _____