

Annual Patient History, Age 0-17

Patient Name (Print) _____ DOB _____

Both Parents/Guardian Names _____

Gender M F

| Any changes to Family History, please explain | | | | | |
|---|---|---|----|---|-----------------------|
| M = Mother F = Father GP = Grandparents S = Sibling | | | | | |
| Description | M | F | GP | S | Age of Onset/Comments |
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PERSONAL HISTORY

Date of last menstrual period (if pertinent): _____

Asthma Yes No Fainting Yes No

Allergies Yes No Describe: _____

Hospitalizations, Cause & Date(s) _____

Health Problems/Illnesses _____

Surgeries, Type & Date(s) _____

Immunizations: Please supply records to our office

Health Habits:

Who do you live with Mother Father Blended Family Self Other: _____ Brother's Age(s) _____ Sister's Age(s) _____

Someone at home smoking Yes No Do you smoke? Yes No

Daily Time on: Computer/Video Games: ___ Hours Watching TV ___ Hours

Attend Daycare/After school care Yes No School grade: _____ Car Seat Used Yes No Seatbelt Used Yes No

History Traumatic Event Yes No Helmet used while cycling/motorcycling: Yes No

Medical marijuana/recreational drugs used Yes No

Drink alcohol? Yes No Fluoride used? Yes No Guns kept in home? Yes No If yes, are they locked up? Yes No

Sexually active? Yes No Dietary concerns Yes No Please describe: _____

Has there been any changes in or new problems which are recurring chronic conditions?

Please explain: _____

Patient signature: _____ Date: _____ Provider's signature: _____ Date: _____