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 = Grandparent S = Sibling					
Description	**M**	**F**	**GP**	**S**	**Age of Onset/Comments**

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)_____

Does someone at home smoke ☐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 of 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: _____

Have there been any changes or new problems with recurring or chronic conditions?

Please explain: _____

Patient signature: _____ Date:_____Provider's signature:_____Date:_____