Patient Name:

the Pediatric Group

13 through 18 years

History form to be filled out
by Parent — CONFIDENTIAL

Date:

Medical History

Do you have any medical problems? ❑ YES ❑ NO
If so, please list:

Have you ever been in the hospital overnight? ❑ YES ❑ NO
If so, for what?

Have you ever had surgery? ❑ YES ❑ NO
If so, for what?

Please list any prescription medicine that you take

Please list any over the counter medicines, herbs, or supplements that you take

Allergy

Any allergies to medicine or foods? ❑ YES ❑ NO

If so, which one(s) and what is the reaction?

Any seasonal or environmental allergies or hayfever? ❑ YES ❑ NO

Immunizations:

Are your shots up to date? ❑ YES ❑ NO

When did you have your last shots?

Social History

Who do you live with?

What school do you go to?

What grade are you in?

Have you ever had to repeat a grade? ❑ YES ❑ NO
If yes, what grade?

Do you feel safe at home? ❑ YES ❑ NO

Are there any firearms in your house? ❑ YES ❑ NO
If so, are they loaded? ❑ YES ❑ NO

Have you ever smoked? ❑ YES ❑ NO
If so, what? How often?

Have you ever drank alcohol? ❑ YES ❑ NO
If so, how much or how often?

Have you been involved in any sexual activity? ❑ YES ❑ NO

Review of Systems (if answer yes, please describe)

Do you wish you weigh more or less than you do now? ❑ NO or ❑ MORE or ❑ LESS

Any problems with your appetite? ❑ YES ❑ NO

Any problems with bowel movements? ❑ YES ❑ NO

Any foods that you avoid due to reactions? ❑ YES ❑ NO
If yes, what food(s) and what type of reactions?

Any problems with eyes, nose, throat? ❑ YES ❑ NO

Do you have a heart problem (for example, do you have chest pains, severe shortness of breath, or feel as if you will pass out with strenuous exercise) ? ❑ YES ❑ NO

Do you have any breathing problems? ❑ YES ❑ NO

Have you ever needed any breathing treatment? ❑ YES ❑ NO

Any problems urinating? ❑ YES ❑ NO

Any problems with muscles, bones, or joints? ❑ YES ❑ NO

Any skin problems? ❑ YES ❑ NO

Are you happy with your grades? ❑ YES ❑ NO

Are your parents happy with your grades? ❑ YES ❑ NO

How many days of school did you miss over the last year?

Any other problems you think we should know about?

For girls:

Have you started periods yet? ❑ YES ❑ NO

If yes, when did you start?

How often do you have your period?

Any problems with heavy bleeding or cramps? ❑ YES ❑ NO