

Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_

Gender preference:  Male  Female  Other: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Preferred Pronoun: \_\_\_\_\_

**\*\*Please bring in a record of your immunizations for us to copy. \*\***

***Please ask your healthcare provider about any questions you do not understand***

**Personal Medical History**

Yes  No Do you have any particular concerns today about your child today? If yes, please explain: \_\_\_\_\_

Yes  No Does your child have any ongoing major medical illnesses (like asthma, diabetes, etc.?) If yes, what? \_\_\_\_\_

Yes  No Does your child take any medicines (daily or as needed)? What? \_\_\_\_\_

Yes  No Does your child take any vitamins, supplements, "alternative" medicines, or therapies? What? \_\_\_\_\_

Yes  No Does your child have any reactions to medicines or immunization? If yes, please explain: \_\_\_\_\_

Yes  No Has your child ever had a surgery or had to spend the night at the hospital? If yes, please explain: \_\_\_\_\_

**Family History**

Unknown/Adopted

Check any of the following problems your parents, brothers, sisters, or other children have had, and state who:

Who?

Who?

Blood disease: \_\_\_\_\_

Heart attack: \_\_\_\_\_

Depression: \_\_\_\_\_

Overweight: \_\_\_\_\_

High blood pressure: \_\_\_\_\_

Alcoholism: \_\_\_\_\_

High cholesterol: \_\_\_\_\_

Physical abuse: \_\_\_\_\_

Suicide: \_\_\_\_\_

Asthma: \_\_\_\_\_

Child abuse: \_\_\_\_\_

Convulsions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Tuberculosis: \_\_\_\_\_

Cancer: \_\_\_\_\_

Drug abuse: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Sexual abuse: \_\_\_\_\_

**Preventive Health**

Yes No

- Does your child use an age-appropriate care seat and/seat belt?
- Does your child always use a helmet when riding a bike, skateboarding, skiing, etc.?
- Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
- Does anyone living with your child smoke?
- Does your child get more than 2 hours of recreational screen time a day (computer, TV, tablets)?
- Has your child seen a dentist in the past 6 months?
- Does your child brush his/her/their teeth daily?
- Has your child been in close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV-positive)?

**Education**

Where does your child go to school? \_\_\_\_\_ What grade are they in? \_\_\_\_\_

What are their average grades? \_\_\_\_\_

Yes  No Does your child have an Individualized Education Plan (IEP)/504 In place?

**Social**

Yes No

- Within the last 12 months, has your child been exposed to a situation where threats, pushing, grabbing, hitting, kicking, breaking things or other hurting has been used?
- Within the last 12 months, has your child experienced any uncomfortable touching? Forced sexual contacts?
- Who does your child live with? \_\_\_\_\_
- Has your child ever been on foster care?

**Review of Systems (Does your child have any CURRENT problems that you'd like to discuss today?)**

Yes No

What?

Yes No

What?

- |   |   |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> vision problems _____                         | <input type="checkbox"/> <input type="checkbox"/> skin problems _____   |
| <input type="checkbox"/> <input type="checkbox"/> breathing problems _____                      | <input type="checkbox"/> <input type="checkbox"/> hearing problems _____  |
| <input type="checkbox"/> <input type="checkbox"/> problems with bowel movements (pooping) _____ | <input type="checkbox"/> <input type="checkbox"/> headaches, fainting, dizziness, any loss of consciousness _____ |
| <input type="checkbox"/> <input type="checkbox"/> stomach problems _____                        | <input type="checkbox"/> <input type="checkbox"/> sleep difficulties, depression, anger, or nervousness _____     |
| <input type="checkbox"/> <input type="checkbox"/> problems urinating (peeing) _____             |   |
| <input type="checkbox"/> <input type="checkbox"/> body aches _____                              |   |

**Females Only**

Yes  No Menstrual irregularities, pain, or concerns about your child's periods? \_\_\_\_\_

**Males Only**

Yes  No Issues with your child's testicles or penis? \_\_\_\_\_

**Other concerns:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For official use only**

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

(over)