

Name: _____

La Pine CHC Pediatric

Date

Date of Birth: _____

Initial History Documentation

HOME ENVIRONMENT (circle where appropriate)

Who lives with child/adolescent?

Mother's name: _____ (Biological / Step / Adoptive / Foster) Lives with child: YES / NO

Father's name: _____ (Biological / Step / Adoptive / Foster) Lives with child: YES / NO

Other (name & relationship): _____

Siblings (at home, first names and age/s): _____

What type of residence: Single family / Multi-family / Trailer / Temporary Was it built before 1978?: YES / NO

Tobacco users/smokers at home: YES / NO

Is anyone a regular user of alcohol/drugs at home: YES / NO

Guns/firearms in the home: YES / NO

Is anyone being hit/hurt or touched inappropriately at home?: YES / NO

Do you have enough money for food?: YES / NO Do you have transportation to get to your appointments: YES / NO

MEDICINES & ALLERGIES

Medication/s taken regularly

Allergies: YES / NONE

_____ To Medications:

_____ To Foods/other (bees, latex):

_____ Was allergy testing done: YES / NO

IMMUNIZATIONS

Do you believe you/your child is completely up-to-date on recommended immunizations?: YES / NOT SURE

Do you have an up-to-date copy of immunizations?: YES / NO

Any reactions or problems?: YES / NO (if yes, please describe)

PAST MEDICAL HISTORY

Birth: Full term (>37 weeks) / Early / Late (circle) Pregnancy lasted ____ weeks (normal is 40)

Birth Weight: ____ pounds ____ ounces

Pregnancy complications:

Tobacco / Alcohol / Drug (circle) use in pregnancy:

Birth complications:

Hospital stay lasted: 1-3 days & routine / prolonged > 3 days due to:

Hearing screen passed: YES / NO

Hospitalizations (list with date/s): _____

Surgeries (list with date/s): _____

Chronic illness/es: _____

Developmental (including speech) **problems/delays:** _____

Psychiatric care / hospitalization/s: _____

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FAMILY HISTORY

Please circle & indicate affected, blood relative/s: Mother, Father, Brother/s, Sister/s, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, Aunts/Uncles/Cousins (indicate maternal/paternal)

Y	N	Diabetes:
Y	N	High blood pressure:
Y	N	High cholesterol:
Y	N	Heart disease:
Y	N	Asthma:
Y	N	Allergic rhinitis/Hay fever:
Y	N	Thyroid disease:
Y	N	Gastrointestinal: (Crohn's, Ulcerative colitis / Irritable bowel / Constipation)
Y	N	Hepatitis:
Y	N	Skin problems: (Eczema / Psoriasis)
Y	N	Abnormal Bleeding or Blood clotting:
Y	N	Mental health: (Depression / Anxiety / Bipolar / Schizophrenia)
Y	N	Kidney disease: (Stones / Infections / Kidney failure)
Y	N	Substance or alcohol abuse:
Y	N	Learning problems or disability: (ADHD / speech/language delay / dyslexia)
		Other:

REVIEW OF SYSTEMS (check if currently present)

	Fever or chills		Abnormal heart beat		Joint stiffness or swelling
	Loss of appetite		Passing out		Limp
	Weight gain or loss (circle which)		Spitting up frequently		Abnormal gait or stance
	Fatigue		Nausea		Pain in arms or legs
	Trouble sleeping		Vomiting		Worrisome or changing moles
	Depressed feelings		Abdominal pain		Hives
	Anxious feelings		Diarrhea		Rash
	Thoughts of death / suicide (circle)		Constipation or irregularity		Blot clots
	Abnormal gaze or eye movements		Heartburn		Easy bruising or bleeding
	Vision loss or disturbance		Painful or difficult swallowing		Swollen lymph nodes
	Eye pain or redness		Blood in the stool		Headache
	Frequent nosebleeds		Pain or burning with urination		Weakness
	Ear pain		Frequent urination		Numbness
	Hearing loss		Blood in urine		Abnormal sensations
	Hoarseness		Incontinence		Females: Painful periods
	Snoring nightly		Excessive urination		Females: Heavy periods
	Shortness of breath		Excessive thirst		Females: Irregular periods
	Cough		Excessive hunger		Females: Vaginal discharge
	Wheezing		Intolerance to cold / heat (circle)		Males: Discharge from penis
	Labored breathing		Excessive sweating		Males: Pain in testicle/s
	Chest pain		Trouble or pain in teeth or mouth		Males: Swelling or lump in testicle/s

Adolescent Health (please answer by circling if you are 12 and older)

Have you ever had sex (includes oral sex)? : YES / NO Have you ever been forced to have sex?: YES / NO

Have you used cigarettes or chewing tobacco?: YES / IN THE PAST / NEVER

Have you used alcohol?: YES / IN THE PAST / NEVER

Have you taken pain pills, marijuana or other substances to get high?: YES / IN THE PAST / NEVER

Do you feel you have been depressed or very worried or anxious? : YES / IN THE PAST / NEVER

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