Meetinghouse Family Physicians

Pediatric/Adolescent Health History

Name: _____ **Date:** _____

Allergies to medicine: Y N If yes, what medicine: _____

Medications/dose: _____ Vitamin/type: _____ Fluoride _____

Any problems during pregnancy or delivery: Y N APGAR 1 min_____ 5 min____

If yes explain: _____

Breast feed Y N How long?_____ Formula amount_____ type _____

Other Or Side Effects

Any significant family history?_____

Any sudden death in the family? Y N Who? _____

Is your home child proof? Y N

Does anyone at home smoke? Y N

Any guns at home? Y N Are they locked up? Y N

Do you use a car seat? Y N Seat belt? Y N

What are your hobbies? _____

Do you play sports? Y N type_____

Are you having any problems at school (grades, fighting, absences)? _____

_____

Do you exercise? Y N Amount: _____

Watch TV hrs/day: _____

Computer hrs/day: _____

Read hrs/day: _____

Video games hrs/day: _____

Are you concerned about your weight? Y N

Ever seen by a psychiatrist/psychologist? Y N

Suicide attempt? Y N

Is your home smoke free? Y N

Do you smoke? Y N

use alcohol? Y N

use illegal drugs? Y N

Are you sexually active? Y N

safe sex? Y N

IMMUNIZATIONS: **Type/date received**

Polio _____ _____ _____ _____

Hepatitis B _____ _____ _____

DTP _____ _____ _____ _____ **DT:** _____

Hib _____ _____ _____ **MMR** ____ _____

Chicken pox _____ **Disease/Yr** _____

Prevnar _____ _____ _____ _____

Any additional information? _____

_____

Please ask the front desk for a record release form to get your records from your previous physician.