FAMILY FIRST PHYSICIANS

Pediatric Patient History Form

Name: _____ Date: _____

Gender: M or F Date of Birth: _____ Age:_____ Parents: _____

What name would you like to be called? _____

How were you referred to Family First Physicians? _____

Please state reason for today's visit: _____

TELL US ABOUT YOURSELF:

School currently attending: _____ Grade in school: _____

Who lives in your household? _____

Siblings: Yes or No How many: _____ Are they healthy?_____

Does anyone in the household smoke? _____

Pets: _____ Sports/extracurricular activities: _____

Do you exercise? Yes or No If yes, what type and how often? _____

How is your diet? _____

OTHER HEALTH CARE PROVIDERS:

Do you see a dentist? Yes or No Last visit date: _____

Do you see an eye doctor? Yes or No Last visit date: _____

Do you see any other physicians or other health providers? Yes or No (If yes, please provide details)

Name: _____ Date of Last Visit: _____
Reason: _____

Name: _____ Date of Last Visit: _____
Reason: _____

BIRTH HISTORY:

Where were you born? (City and hospital) _____

Birth weight: _____ Type of delivery (choose one): Vaginal C-Section Forceps Vacuum

How many weeks gestation? _____ If premature, how long in NICU?_____

Any problems or complications during pregnancy or delivery?_____

IMMUNIZATIONS:

Up to date? **Yes or No** Any adverse reactions? If yes, please explain. _____

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PAST OR PRESENT DISEASES OR SERIOUS ILLNESSES:

Disease	First Diagnosed (Month/Year)	Treated By

SURGERIES or HOSPITALIZATIONS:

Surgery or Illness	Reason	Date (month/year)

ALLERGIES OR ADVERSE DRUG REACTIONS?

Medication Name	Type of Reaction	When

MEDICATIONS:

Name	Strength and Dose	How often taken

NON-PRESCRIPTION: (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, supplements, etc.)

Name	Strength and Dose	How often taken

HERBAL PREPARATIONS or HOMEOPATHIC REMEDIES:

Name	Strength and Dose	How often taken

FAMILY HISTORY:

Have any of your immediate family members had any of the following conditions?

Illness/Condition	Yes	No	Relationship to Patient	Illness/Condition	Yes	No	Relationship to Patient
Cancer				Thyroid disease			
Heart disease/heart attack				Depression/anxiety			
Stroke				Mental illness			
High blood pressure				Autoimmune disease			
High cholesterol				Other: (please list)			
Diabetes							
Sudden death before age 60?							

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CHILDREN 12 AND OLDER ONLY

If you ride a motorcycle or bicycle, do you always use a helmet?	Yes	No	
Do you always use your seat belt when in a car?	Yes	No	
Do you ever drive, or ride with a driver who is, under the influence of alcohol or drugs?	Yes	No	
If you drive, do you ever text while driving?	Yes	No	
Do you or any of your friends have access to a gun?	Yes	No	
Has anyone ever touched you in a way that made you uncomfortable or afraid?	Yes	No	
Do you get along with your family?	Yes	No	
Are you having a hard time at home or school?	Yes	No	
Are you having a hard time with friends including your boyfriend or girlfriend?	Yes	No	
Are you having trouble with fighting or bullying?	Yes	No	
During the past 2 years, have you or anyone in your family had any major changes?	Yes	No	
Do you have any concerns about your body or weight?	Yes	No	
Do you ever eat in secret or feel guilty about eating?	Yes	No	
Do you ever make yourself throw up?	Yes	No	
Have you recently lost interest or pleasure in doing things you used to enjoy?	Yes	No	
Have you been feeling down, depressed, irritable, or hopeless?	Yes	No	
Have you ever used tobacco (cigarettes, cigars, or chew)?	Yes	No	
Do you ever use alcohol or drugs?	Yes	No	
Do you ever use alcohol or drugs while you are by yourself, alone?	Yes	No	
Who are you attracted to?	Males	Females	Both
Have you ever had sex?	Yes	No	
If YES, were your sexual partners	Male	Female	Both
When you have sex, do you always use a condom?	Yes	No	
When you have sex, do you use any other contraception besides condoms?	Yes	No	

FEMALES ONLY (If applicable)

Age Periods Began: _____ First Day of Last Menstrual Period: _____

Current Menstrual Cycles:
How Often: _____How Many Days: ____ Flow: (circle) Light Moderate Heavy Pain with Periods: Yes or No

Date of Last Pap: _____ Results: _____

Have you ever had an abnormal pap smear? Yes or No If yes, what type of abnormality? _____
Treatment: _____ Date (Month/Year): _____

Have you ever been treated for any sexually transmitted diseases? (circle all that apply)
Syphillis Gonorrhea Chlamydia Herpes Genital Warts Other _____

Have you ever been pregnant? Yes or No

Are you using any type of contraception? Yes or No (circle) If so, what type are you using? (Circle all that apply)
Birth Control Pills (Name) _____ IUD (date inserted) _____
Depo-Provera Diaphragm Condoms Sponge Other_____