GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

Health History
PEDIATRIC (3-17 years)

Last Name:_____ **First Name:**_____ **DOB:** _____

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Relative, relationship:_____
☐ Adopted (year joined family:_____ ☐ Foster (year joined family:_____

Past Medical History: (please mark any that apply and explain)

☐ Abdominal complaints
☐ ADHD
☐ Allergies
☐ Asthma / Wheezing
☐ Cancer (type:_____)
☐ Depression
☐ Diabetes
☐ Ear infections
☐ Headaches
☐ Heart condition / Murmurs
☐ Kidney disease
☐ Sore throat (frequent)
☐ Thyroid
☐ Urinary tract infections

Explanation/Other:_____

Any serious injuries: ☐ Concussions ☐ Fractures Other (specify):_____
If any checked, how many:_____ Age(s) when injured:_____

Past Surgeries / Hospitalizations: (please list any surgeries or hospitalizations, date, and reason)

Surgery / Hospitalization	Date	Reason
1.		
2.		
3.		
4.		
5.		

Medications: (please include over-the-counter, herbal supplements, vitamins, birth control if applies)
☐ No medications at all ☐ See attached medications list

Medication	Dose	How Often
1.		
2.		
3.		
4.		
5.		

Allergies: ☐ Drug/medication allergies (*please explain below*):
Explanation:_____
_____
_____

☐ No known drug allergies
☐ Animals ☐ Food
☐ Environmental
☐ No allergies at all

Other providers involved in child's care: (please include dental, therapists, specialists, etc.)

Name	Specialty	Reason / Last visit
1.		
2.		
3.		
4.		
5.		

Today's Date:_____

Turn over for page 2.

Review of Systems: (please check system(s) and circle the condition(s) that apply today)

- ☐ **Breasts**: Skin changes, mass, pain, discharge
- ☐ **Ears**: Hearing loss, ringing, pain, discharge
- ☐ **Eye**: Visual change, blurred vision, glasses, redness, pain
- ☐ **Endocrine**: Heat/cold intolerance, excessive sweating, frequent urination, excessive thirst, thyroid problems, diabetes
- ☐ **GI**: Stomach-ache, nausea, vomiting, diarrhea, constipation, blood in stool, hemorrhoids
- ☐ **General**: Fever, chills, weight change, weakness
- ☐ **Genital**: Discharge, sores, itchy, abnormal periods
- ☐ **Head**: Trauma, concussion, headache
- ☐ **Heart**: Chest pain, murmurs, palpitations, swelling, trouble lying flat
- ☐ **Hematologic**: Anemia, easy bruising, bleeding, transfusions
- ☐ **Lungs**: Short of breath, wheeze, cough, asthma
- ☐ **Mouth / Throat**: Sore, hoarseness, cavities, blisters
- ☐ **Muscles / Bones**: Weakness, pain, joint stiffness
- ☐ **Neuro**: Dizziness, loss of sensation, weakness, tremor, tingling, fainting
- ☐ **Nose**: Runny, bloody, sneezing, itchy
- ☐ **Psychiatric**: developmental delays, autism, potty training difficulty, speech, depression, anxiety, attention
- ☐ **Skin**: Rash, hair change, nail change, moles
- ☐ **Urine**: Painful, frequency, discharge, blood
- ☐ **Vessels**: Leg swelling, painful walking

Explanation/Other:_____

Family History: (please mark the illnesses/conditions that <u>any members</u> of your family may have/had)

	Diabetes	Heart Disease	High BP	Stroke	High Cholesterol	Depression/ Mental Illness	Thyroid	Cancer (type)	Other (list)
Mother ☐Alive ☐Deceased	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Father ☐Alive ☐Deceased	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Sibling(s) ☐Alive ☐Deceased	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	

Health Maintenance:

Is child up to date with childhood immunizations? ☐ Y ☐ N ☐ Unknown ☐ N/A

If no / unknown, would you like to discuss vaccines that are due today? ☐ Y ☐ N

Social History:

Parents Marital Status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Childcare away from parents: ☐ None ☐ Relative ☐ Nanny ☐ Private sitter ☐ Daycare

Does the child attend school: ☐ Y ☐ N *If yes,* which grade:_____Grades in school:_____

Child's diet is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Special diet (vegan, diabetic, gluten-free)

Caffeine intake: ☐ Y ☐ N *If yes,* amount:_____Seatbelt or car seat use: ☐ Y ☐ N

Pets in the home: ☐ Y ☐ N *If yes,* what types_____

Smoke exposure in the home: ☐ Y ☐ N CO_2 detectors in the home? ☐ Y ☐ N

Guns in the home: ☐ Y ☐ N Where stored: ☐ Inside ☐ Outside Locked: ☐ Y ☐ N

Bike helmet use: ☐ Always ☐ Only w/mountain bike or motorized ☐ Never

Bullying: ☐ Y ☐ N Marijuana: ☐ Y ☐ N Alcohol: ☐ Y ☐ N

Exercise: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Sports:_____

Working: ☐ Y ☐ N *If yes,* type of work:_____ Employer:_____