NEW / WELL PEDIATRIC PATIENT – 11 through 17 YEARS

MAGNIFICAT FAMILY MEDICINE LLC

Name:_____ Date of Birth:_____

Sex: Male☐ Female☐ Today's Date:_____

Accompanying Adult's Name/Relation:_____

Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns to discuss with the doctor today:

_____

Please list your child's **CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS:**

Name	Dosage (i.e., MG)	How Taken (i.e., 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (i.e., rash, nausea

IMMUNIZATION PREFERENCE (circle one): **Traditional**☐ **Delayed**☐ **None**☐

Please provide your child's **IMMUNIZATION HISTORY:**

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster	☐	☐		Hepatitis A Vaccine	☐	☐	
Influenza Vaccine (Flu Shot)	☐	☐		Hepatitis B Vaccine	☐	☐	
Pneumococcal Vaccine	☐	☐		Human Papilloma Virus (HPV)	☐	☐	
Tuberculosis (TB) Skin Test	☐	☐		Varicella Vaccine	☐	☐	

Please provide your child's **PAST MEDICAL HISTORY:**

☐ADD/ADHD
☐Abdominal Pain
☐Acne
☐Allergic Rhinitis
☐Allergies
☐Anemia
☐Asthma
☐Bleeding Disorder
☐Bronchiolitis
☐Bronchitis
☐Chicken Pox
☐Concussion, CHI
☐Congenial heart disease
☐Constipation
☐Diabetes
☐Eczema
☐Fracture
☐GERD (reflux)
☐Headaches
☐Hearing problems
☐Heart murmur
☐Menstrual problems
☐Migraines
☐Pneumonia
☐Prematurity
☐Pyelonephritis
☐Recurrent otitis media
☐Seizure disorder
☐Seizures - febrile
☐ UTI
☐Vesicoureteral reflux
☐_____: Other

For Nurse Use Only: Ht._____Wt._____Temp._____BP._____Pulse_____Resp._____SpO2_____VS; R_____L_____

Please tell us about any **SURGERIES** your child has had, indicate the **date/year if known:**

☐ Appendectomy
☐ Inguinal Hernia Repair
☐ Fracture with Small Reduction
☐ Dental Surgery
☐ Tonsillectomy
☐ Adenoidectomy
☐ PET placement
☐ Lymph node biopsy/excision
☐ Umbilical Hernia Repair
☐ Hernia repair
☐ : Other

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY**:

_____

Please provide age-appropriate **SOCIAL HISTORY:**

Primary Residence:
Who lives with your child?_____
_____

Tobacco Exposure:
Are there smokers at home? Yes ☐ No ☐
If yes, do they smoke outside only? Yes ☐ No ☐

Home Environment:
What is the age of the home?: _____
Is there lead in the home? Yes ☐ No ☐
_____
Spiritual belief/Religion:_____
Education:
School Name:_____
School Grade:_____
Does child have any learning disabilities?
_____
Does child have any special needs?
_____

Child Care:

Who provides care for your child?	#days/wk:
☐ Mother	_____ days/wk.
☐ Father	_____ days/wk.
☐ Grandparent	_____ days/wk.
☐ Other _____	_____ days/wk.
☐ Day Care	_____ days/wk.

Activity:
Exercise/Sports: _____ hrs./day
TV/Computer Games: _____ hrs./day

Sleep:
Does child get 8.5 hrs. of sleep? Yes ☐ No ☐
Does child have sleeping problems? Yes ☐ No ☐
Does child take naps? Yes ☐ No ☐
Does child sleep with parents? Yes ☐ No ☐
Does child sleep through the night? Yes ☐ No ☐
What position does child sleep in?_____

Safety:
Does child use a car seat? Yes ☐ No ☐
If yes, is car seat facing: Front ☐ Rear ☐
Is there a carbon monoxide detector? Yes ☐ No ☐
Are smoke detectors in the home? Yes ☐ No ☐
Are there firearms in the home? Yes ☐ No ☐
Are there pets in the home? Yes ☐ No ☐
If yes, what kind?

Please provide additional **SOCIAL HISTORY** as appropriate:

Do they Smoke? Yes ☐ No ☐ Former ☐
Type of tobacco: _____
Packs per day: _____
Years smoked: _____
Years quit:_____
Have they ever tried to quit? Yes ☐ No ☐
Job:_____
Last Grade Completed: _____
Hours a Day watching TV:_____
Exercise: #of days/wk:_____ #of hrs./day_____
Have they seen a counselor? Yes ☐ No ☐
If yes, what for?_____

Are they currently sexually active? Yes ☐ No ☐ Former ☐
Total # of Lifetime Partners:_____

Alcohol consumption? Yes ☐ No ☐ Former ☐
Type of alcohol:_____
Frequency and Amount: _____
When was last drink? _____
Use of Illegal drugs? Yes ☐ No ☐ Former ☐
Type of drug:_____
Frequency and Amount:_____
Do they have an eating disorder? Yes ☐ No ☐ Former ☐
Do they view pornography? Yes ☐ No ☐ Former ☐
Other Addictions?_____

FOR FEMALES ONLY:

Age at First Period: _____ Are periods ☐ Regular ☐ Irregular Cycle Length (days): _____

Date of Last Menstrual Period: _____ ☐ Hysterectomy # of days Bleeding: _____

Date of Last Mammogram:_____ Is Flow: ☐ Normal ☐ Heavy ☐ Light ☐ Spotting # of Pregnancies: _____

Date of Last Pap Smear: _____ Do you have pain with period? Yes ☐ No ☐ # of Live Children:_____

Any history of abnormal pap smears? Yes ☐ No ☐ Or any of the following: ☐ Pelvic Pain # of Miscarriages:_____

If Yes, When: _____ ☐ Back Pain ☐ Breast Tenderness # of Abortions: _____

☐ Mood Swings ☐ Headaches

Please provide your child's **FAMILY HISTORY:**

FATHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? _____

Health Problems_____

MOTHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? _____

Health Problems_____

BROTHERS AND SISTERS: (Each one: Are they living? Reason Deceased? Ages? Other health problems?)

_____

_____

_____

OTHER: (NAMES AND AGES, Are they living? Reason Deceased? Ages? Other health problems?)

_____

_____

_____

Does anyone in the family have these health conditions? (Please check even if listed above)

☐ Heart Problems (Heart Attacks, Heart Failure)

☐ Breast Cancer

☐ Colon Cancer

☐ Prostate Cancer

☐ Skin Cancer

☐ Diabetes

☐ Strokes

☐ Mood Disorders (Anxiety, Depression, Bipolar, etc.)

HEALTH MAINTENANCE: (Please List Date)

Last Dental Appointment: _____

Last Eye Doctor Appointment:_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN REVIEWED: _____ **DATE:** _____