

Cornerstone Family Practice New Child/Adolescent Health History

Name: _____

Date: _____

Age: _____

Date of Birth: _____

Medications: Please list all prescription and OTC meds with dosages.

1.	4.
2.	5.
3.	6.

Allergies: Please list drug, food and environmental allergies and type of reaction

1.	4.
2.	5.
3.	6.

Past Medical History:

Medical: Please check any medical problem patient has had and date/year.

- | | |
|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis/Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Drug or Alcohol Problems | <input type="checkbox"/> Premature birth |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Rashes/Eczema |
| <input type="checkbox"/> Eating disorders/Anorexia or Bulimia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sexually transmitted Disease |
| | Other _____ |

Girls only:

Have menstrual periods started? _____ Age they started _____

First Day of Last Menstrual Period _____

Surgical: Please list all prior surgeries and dates:

1.
2.
3.
4.
5.

Immunizations: Please check if child has had the following vaccines and dates:

DTaP#1	#2	#3	#4	#5
Polio#1	#2	#3	#4	
Hib#1	#2	#3	#4	
Prevnar#1	#2	#3	#4	
Hepatitis B #1	#2	#3		
MMR #1	#2			
Varicella#1	#2			
Hepatitis A #1	#2			
Influenza (last year received)				
Gardasil #1	#2	#3		
Other:				

Current Household members: Please not age and relationship to patient:

1.	4.
2.	5.
3.	6.

Family History: Please list family members with any of the following diseases:

Alcohol/Drug Abuse	Skin Cancer
Asthma/Allergies	Thyroid Cancer
Birth Defect/Genetic Disease	Depression/Psychiatric Problems
Breast Cancer	Diabetes
Cervical Cancer	Heart Disease/Attack
Colon Cancer	High Blood Pressure
Lung Cancer	High Cholesterol
Ovarian Cancer	Migraines
Prostate Cancer	Stroke

Social History:

Exercise: None ___ 1-2x/week ___ 3-4x/week ___ 5-7x/week ___

Tobacco use: Yes ___ packs per day ___ Nonsmoker ___

Alcohol use: Yes ___ drinks per week ___ None ___

Sexually active: Yes ___ No ___ number of partners? ___ Birth control ___

Drug use: yes ___ No ___ Type of drugs used ___

Performing well in school? Yes ___ No ___ Average Grades ___

Participates in extracurricular activities Yes ___ No ___ Type ___

Interacts well with peers Yes ___ No ___