Pediatric and Adolescent Health History
Ages 0-17

Pt Name: _____

DOB: _____

Patient #: _____

Date of Service: _____

Form completed by: ☐ Patient ☐ Parent/Guardian ☐ Other _____
Is child less than 5 years of age? ☐ Yes ☐ No
If Yes, complete the next section. If not continue to Past Medical History

Birth History (Please complete if child is less than 5 years of age)

Birth History	☐ Biological ☐ Adopted ☐ Foster Care ☐ Surrogate
Type of Delivery	☐ Vaginal ☐ Cesarean Section
Was the child in intensive care after birth?	☐ Yes ☐ No If Yes, please explain _____
Child's weight at birth	_____ Pounds _____ Ounces
Was child a multiple birth (e.g., twin, triplet)?	☐ Yes ☐ No
Were there any complications associated with the pregnancy or delivery?	☐ Yes ☐ No If Yes, please explain _____

Did the person carrying the child experience any of the following during pregnancy:

	Yes	No	Unknown
Diabetes			
Smoking			
Cigarette smoke in the home			
Alcohol			
Drugs			
Hepatitis C			
Sexually Transmitted Infections (e.g., gonorrhea, chlamydia, syphilis)			
Other (Please list any illness not listed above)			

complete HEALTH

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Past Medical History

☐ No Past Medical History
☐ Unattainable Past Medical History

Integumentary (Skin) ☐ Skin disorders ☐ Other _____	**Ear/Nose/Throat** ☐ Glasses/Contacts	**Respiratory** ☐ Asthma ☐ RSV ☐ Pneumonia	**Endocrine** ☐ Diabetes Type I ☐ Diabetes Type II ☐ Thyroid	**Hematologic** ☐ Blood Disorders ☐ Anemia
Cardiovascular ☐ Congenital Heart	**Genitourinary** ☐ Kidney Problems	**Neurologic** ☐ Epilepsy	**Cancer**	
Sexual Health ☐ STI's ☐ HIV ☐ Gonorrhea ☐ Chlamydia	**Allergies** ☐ Allergic Rhinitis ☐ Food Allergies ☐ Other allergies	**Developmental** ☐ Developmental Delay ☐ Autism	**Psychosocial** ☐ ADHD ☐ Depression ☐ Anxiety ☐ Mood Disorder	

Other Medical Problems not Listed

Does your child see any specialty providers? ☐ Yes ☐ No

If Yes, please list

Surgical History

Has child had any prior surgeries?	☐ Yes ☐ No
Ear/Nose/Throat ☐ Dental ☐ Myringotomy (Tubes in Ears) ☐ Sinus ☐ T&A (Tonsillectomy/Adenoidectomy) ☐ Thyroid	**Cardiothoracic** ☐ Lung surgery Explain _____ ☐ Heart Surgery Explain _____
Abdominal ☐ Appendectomy ☐ Bladder Surgery ☐ Cholecystectomy (gallbladder) ☐ Hernia repair ☐ Kidney surgery ☐ Pyloric Stenosis	**Orthopedic** ☐ Joint or bone surgery Explain _____
Other Surgeries not listed:	

complete HEALTH

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Social History

How would you describe your child's housing situation?	☐ Biological mom ☐ Biological dad ☐ Stepmom ☐ Stepdad ☐ Biological grandparents ☐ Relatives other than biological parents. Explain _____ ☐ Foster Home ☐ Juvenile Group Home (Ward of State or County) ☐ Homeless shelter ☐ Another living situation not listed. Explain _____	
Does your family feel safe in their current living situation?	☐ Yes ☐ No	
Does child use alcohol?	☐ Yes ☐ No	
Does child use marijuana?	☐ Yes ☐ No	
Does child use tobacco?	☐ Yes ☐ No	
Does child use illegal drugs?	☐ Yes ☐ No	
Has the child ever been physically abused?	☐ Yes ☐ No	If Yes, Reported ☐ Yes ☐ No
Has the child ever been mentally abused?	☐ Yes ☐ No	If Yes, Reported ☐ Yes ☐ No
Has the child ever been sexually abused?	☐ Yes ☐ No	If Yes, Reported ☐ Yes ☐ No
What grade and school does your child attend?		
Does child have IEP or 504 plan?	☐ Yes ☐ No	
Is child sexually active?	☐ Yes ☐ No If Yes, current form of birth control. _____ If no, has child ever been sexually active? ☐ Yes ☐ No	
What words does your child use to describe their gender?	☐ A boy ☐ A girl ☐ Both ☐ Something else: _____ ☐ It changes over time ☐ I do not know ☐ I do not want to say	
How would your child describe their sexual orientation or sexual identity? 0 to 11 years of age		
If child is 12 years of age or older, complete this question.	☐ Straight (attracted to other gender(s) or sex(s) from their own) ☐ Same-gender loving ☐ Same-sex loving ☐ Lesbian ☐ bi-sexual ☐ Gay ☐ Pansexual ☐ Pansexual ☐ Asexual ☐ Queer ☐ Questioning ☐ Do not know ☐ Don't want to answer ☐ Not listed. _____ ☐ I do not know what this question is asking.	

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☐ No biological Maternal Family History ☐ No biological Paternal Family History
☐ Biological Mother Deceased ☐ Biological Father Deceased

Please indicate who in child's immediate family had any of below listed conditions: biological paternal grandmother (PGM), biological paternal grandfather (PGF), biological maternal grandmother (MGM), biological maternal grandfather (MGF).

	Mom	Dad	Sister	Brother	PGM	PGF	MGM	MGF
Dermatology:								
Eczema								
Psoriasis								
Ophthalmology:								
Blindness								
Otolaryngology:								
Hearing Loss								
Allergies:								
Respiratory:								
Asthma								
Cystic Fibrosis								
Cardiovascular:								
Hypertension								
High Cholesterol								
Heart Disease								
Congenital Heart								
Stroke								
Gastrointestinal:								
Irritable Bowel								
Crohn's								
GERD								
Renal Disorders:								
Rheumatology:								
Rheumatoid Arthritis								
Lupus								
Endocrinology:								
Diabetes Type 1								
Diabetes Type 2								
Thyroid Disorder								
Hematology:								
Anemia								
Bleeding Disorder								
Leukemia								