PACIFIC FAMILY PRACTICE

Pediatric New Patient History - Adolescent / Teen

Child's Name (Last, First, MI)	DOB	M / F	Today's Date

Parent(s) Names	Contact Phone Number for Parent / Guardian:

Siblings (Please list name and age):

Medical History

Allergies? YES ☐ NO ☐

To Medications? (Please List)

To Foods / Other? (Please List)

Type of Allergic Reaction: ☐ Rash ☐ Hives ☐ Respiratory Problems

Medical History (Please circle all that apply)

Colds/Respiratory infections	☐	Diaper Rash	☐
Ear Infections	☐	Sore throats	☐
Asthma	☐	Eczema	☐
Other?	☐		

Medications:

Medication:	Dosage:	Medication:	Dosage:

Hospitalizations / Surgeries / ER Visits (List Reasons & Dates):

Family History

Has anyone in the family ever had the following? (Please circle all that apply and state relationship to child):

SIDS	Epilepsy
Asthma	Depression / Anxiety
Allergies	Sickle cell disease
Diabetes	Learning disabilities
Cancer	Autism spectrum disorders
Drug / Alcohol Abuse	Very high Cholesterol
Heart attack before age 55	Other mental illness

Safety

Do you wear your seatbelt? YES ☐ NO ☐

Do you wear helmets when biking? YES ☐ NO ☐

Have you ever been hit, kicked, pushed or slapped? YES ☐ NO ☐

Females Only

Have you started your period? YES ☐ NO ☐

Are you happy with your weight? YES ☐ NO ☐

If Yes, when was the first day of your last period?	
Are your periods regular (i.e. every 28-35 days)	
Are your periods light, regular, heavy?	