NEW PEDIATRIC PATIENT – 11 YEARS TO 17 YEARS

BARRY POINTE FAMILY CARE, LLC
Your Medical Home

Name: _____

Birth Date: _____ Today's Date: _____

If minor, accompanying adult's name: _____

Please tell us the **TOP THREE REASONS FOR TODAY'S VISIT IN ORDER OF IMPORTANCE**: _____

_____

Please list **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

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

Allergy	Type of Reaction (ie, rash, nausea, swelling)

Please provide **IMMUNIZATION HISTORY:** **Please provide a copy of immunization record.**

	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 **PAST MEDICAL HISTORY**:

_____ADD/ADHD
_____Abdominal Pain
_____Acne
_____Allergic Rhinitis
_____Allergies
_____Anemia
_____Asthma
_____Bleeding Disorder
_____Bronchiolitis
_____Bronchitis
_____Chickenpox
_____Concussion, CHI
_____Congenital heart disease
_____Constipation
_____Diabetes
_____Eczema
_____Fracture
_____GERD(reflux)
_____Headaches
_____Hearing problems
_____Heart murmur
_____Menstrual problems
_____Migraines
_____Pneumonia
_____Prematurity
_____Pyleonephritis
_____Recurrent otitis media
_____Seizure disorder
_____Seizures – febrile
_____UTI
_____Vesicoureteral reflux

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if know**n:

_____Appendectomy
_____Inguinal Hernia Repair
_____Fracture with Surgical Reduction
_____Dental Surgery
_____Tonsillectomy
_____Adenoidectomy
_____PET placement
_____Lymph node biopsy/excision
_____Umbilical Hernia Repair

For Nurse Use Only: Height_____ Weight_____ Temp_____ BP_____ Pulse_____ Resp_____

Please list any **ADDITIONAL PAST MEDICAL HISTORY** or **PAST SURGICAL HISTORY** and date/year if known:

_____

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Allergies					
Asthma					
Birth Defects					
Cancer, Type					
Coronary artery disease (heart disease)					
Deafness					
Depression					
Developmental delay					
Diabetes					
Eczema					
Genetic disorder					
Hemoglobinopathy					

	Mother	Father	Sister	Brother	Other
High cholesterol					
High blood pressure					
Hip Dysplasia					
Learning disability					
Mental retardation					
Migraines DDH					
Obesity					
Scoliosis					
Seizure disorder					
SIDS					
Strabismus (crossed eyes)					
Thyroid disease					
Other:					

Please provide your **SOCIAL HISTORY**:

Who lives with your child? _____

Tobacco Exposure	**Yes**	**No**
Are there smokers in the house?		
If yes, do they smoke outside only?		
Home Environment	**Yes**	**No**
What is the age of the home?		
Is the water chlorinated?		
Is the water fluoridated?		
Is there lead in the home?		
Activity		
Exercise/Sports hours/day:		
TV/Computer Games hours/day:		

Safety	**Yes**	**No**
Does your child use a bike/skate helmet?		
Does your child use seat belt in car?		
Are smoke detectors in the home?		
Is there a carbon monoxide detector?		
Are there firearms in the home?		
Are there pets in the home?		
If yes, what kind(s)?		

Do you smoke: ___Yes ___No ___Former Type of tobacco: _____ Packs per day: _____

Do you use drugs: ____Yes ___No ___Former Type: _____ Frequency: _____

Do you drink alcohol: ____Yes ____No ____Former Age started: ____ Type of alcohol: _____

Frequency: _____ Amount: _____

FOR FEMALES ONLY:

Age of First Period: _____ Date of last Menstrual Period: _____ Date of last Mammogram: _____

Date of last Pap Smear: _____ Any history of abnormal Pap Smear? ____Yes ____No If yes, when: _____

Are Periods regular: ____Yes ____No Do you have pain with periods: ____Yes ____No

Is flow: ____Normal ____Heavy ____Light ____Spotting

Number of pregnancies: ____ Number of live children: ____ Number of miscarriages: ____ Number of abortions: ____