# 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.

___ Acne
___ Anemia
___ Asthma
___ Attention Deficit Disorder
___ Drug or Alcohol Problems
___ Depression
___ Eating disorders/Anorexia or Bulemia
___ Feeding difficulties
___ Heart murmur
___ High Cholesterol
___ Hepatitis/Liver Disease
___ Headaches
___ Jaundice
___ Premature birth
___ Rashes/Eczema
___ Seizures
___ Stomach problems
___ 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:

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|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

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

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|---|
| 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______