Group Health
TriHealth Physician Partners

PEDIATRIC AND ADOLESCENT HISTORY

PCP: _____

Date: _____

Patient's Name _____ Age: _____ Birthdate: _____ Sex: _____
Last First Middle Initial

Recent foreign residence: Patient: _____ Mother: _____ Father: _____

Father's Name _____ Age: _____ Phone (H): _____ Phone (Work): _____

Mother's Name _____ Age: _____ Phone (H): _____ Phone (Work): _____

Marital Status of Parents: _____ Legal Guardian of Patient: _____

Other Children:
Name(s): _____ Age: _____ Birthdate: _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

Has anyone in the patient's family had any of the following? If yes, please indicate the person's relationship to the patient.

	No	Yes	Relationship		No	Yes	Relationship
Allergies				Eye problems			
Anemia				Heart attack/heart problems			
Arthritis				High blood pressure			
Asthma				Kidney disease			
Birth Defects				Lung disease			
Blood Disorder				Mental disorders/depression			
Cancer				Seizures/epilepsy			
Elevated cholesterol				Stomach/intestinal/liver disease			
Sudden (unexpected) death				Stroke			
Diabetes				Tuberculosis			
Drug/alcohol abuse				Other:			

PATIENT HISTORY

Birth History: (circle or complete for each line) Full term / Premature (If premature, how early? _____)

Birth Weight: _____ length: _____ Vaginal / Forceps / C-section (Reason: _____)

Problems at delivery or in nursery: _____

Problems during pregnancy: _____

Other: _____

Infectious Diseases: (please indicate if the patient has experienced any of the following and at what age)

	No	Yes	Age (or date)		No	Yes	Age (or date)
Chicken Pox				Mumps			
Hepatitis				Tuberculosis			
Measles				Whooping Cough			
Mononucleosis				Other:			

(OVER)

Medical History: (please indicate if patient has experienced any of the following and at what age)

	No	Yes	Age (or date)		No	Yes	Age (or date)
Anemia				Heart problem/murmur			
Asthma				Kidney or Bladder Infection			
Allergies/Hayfever				Meningitis			
Bedwetting				Menstrual Problems			
Behavior Problem/Depression				Nosebleeds			
Bone/Joint Infection				Pneumonia			
Elevated Cholesterol				Pregnancy			
Diabetes				School Problems/ADD			
Drug/alcohol abuse				Seizures/Epilepsy			
Ear Infections				Skin Disease			
Eating/Feeding Problems				Smoking/Smoke Exposure			
Fracture				Soiling of underpants (urine/stool)			
Glasses/Contacts/Eye Problems				Thyroid Problems			
Head Injury				Tonsillitis/Strep Throat			
Hearing Problem				Other:			

Please explain any “yes” answers above: _____

_____

_____

_____

_____

Allergy to Medicine (name of medicine and type of reaction): _____

_____

Hospitalizations: _____

_____

_____

Surgeries: _____

_____

Specialist Visits/Consults: _____

_____

Current Medications (including birth control and inhalers): _____

_____

OFFICE USE ONLY: