12-21 YEAR OLD

NAME _____
DATE _____

pediatrics NORTHWEST PS Mary Bridge Children's
www.pedsnw.net

PERSONAL MEDICAL HISTORY

No — Have you ever had any reactions to medications or immunizations?
Select — Do you take any medications (daily or as needed)?
Select — Do you take any vitamins, supplements, "alternative" medicines, or therapies?
Select — Do you have any ongoing major medical illnesses (like asthma, diabetes, etc?) What? _____
Select — Have you ever had surgery or had to spend the night at the hospital?
Select — Have you ever been diagnosed with an immunodeficiency?
Select — Are there any major changes or stresses in the family (moves, deaths, separation, etc)?

FAMILY HISTORY

Select — Are there any major illnesses in the family? Which ones? _____
Select — Is there any family history of sudden cardiac death or arrhythmias?
Select — Does either parent have elevated cholesterol or been prescribed a cholesterol medication?
Select — Has any family member died of heart problems or of sudden death **BEFORE AGE 50**?
Select — Has anyone in your family died for no apparent reason?
Select — Does anyone in your family have Marfan syndrome, sickle cell anemia/trait?

NUTRITION

Select — Do you have at least 4-5 servings of fruits/vegetables each day?
Select — Do you have at least 2-3 servings of calcium each day? (milk, cheese, yogurt or supplements)?
Select — Do you drink anything other than milk and water?
_____ — How many times per week do you eat fast food?

PREVENTIVE HEALTH

Select — Have you seen a dentist in the past 6 months?
Select — Do you always wear a seat belt?
Select — Do you use a cell phone or use headphones while driving?
Select — Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
Select — Have those alarms been checked in the past 12 months?
Select — Do you always use a helmet when riding a bike, skateboarding, skiing, etc.?
Select — Do you live with anyone who smokes?
Select — Have you had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV positive)?
_____ — How many hours of recreational screen time per day (internet, mobile apps, video games, movies)?
Select — Do you have a screen (computer, tablet, phone, TV, etc.) in your bedroom?
Select — Do you have any concerns about your sleep or sleep habits?

REVIEW OF SYSTEMS (*Do you have any **CURRENT** problems with the following that you'd like to discuss today?)*

Select — headaches, fainting, dizziness, any loss of consciousness
Select — eyes, vision, ear pain, hearing, nosebleeds, or snoring that disrupts your sleep
Select — coughing, breathing, shortness of breath, wheezing, limited endurance, or chest pain
Select — breast lump, discharge or pain
Select — frequent stomachaches, vomiting, diarrhea, constipation, or blood in the stools
Select — urination (change in frequency, or blood in the urine)
Select — neck, back, or extremities (feet, legs, arms, hands)
Select — rashes, sores, or acne
Select — moles or birthmarks that are growing, changing or that you are concerned about
Select — sleep difficulties, depression, anger, or nervousness

FEMALES

_____ — When was your first menstrual cycle (years old)?
_____ — When was the first of day of your most recent period?
Select — menstrual irregularities, pain, or other concerns about your period

Please continue on the other side.

MOOD

*Over the **past 2 weeks***, how often have you been bothered by the following problems:

Little interest or pleasure in doing things: Select

Feeling down, depressed, or hopeless: Select

ACADEMIC

What school do you attend? _____ What grade level? _____

Select Are you scoring on or above grade level?

Select Do you enjoy reading?

Select Are you involved in extracurricular activities? Which ones? _____

Select Do you receive any extra services, tutoring, PT, OT, speech therapy, etc

Select Does the school have any concerns about your academics or behavior?

Select Do you have any concerns about your academics?

VISION/ HEARING

Per recommendations by the American Academy of Pediatrics (AAP), our providers will routinely order a vision screen and a hearing screen unless your child had one within the past 12 months. These are separate charges in addition to the Well Child visit charge. A few insurance plans do not cover hearing and vision screenings. We strongly recommend that you review your insurance plans coverage prior to your appointment.

If your child has had a hearing or vision screen in the past 12 months, please indicate below:

Recent Hearing Screen Date _____ Recent Vision Screen Date _____

☐ I prefer that my child NOT receive a Hearing or Vision screen today. (Please select one or both) Select

PHYSICAL ACTIVITY QUESTIONS

Select Do you consider yourself physically active?

No Has a health care provider ever denied or restricted your participation in sports for any reason?

Select Have you ever passed out or nearly passed out **WHILE** you are actually running or exercising?

Select Have you ever passed out or nearly passed out **AFTER** you stopped running or exercising?

Select Have you ever had discomfort, pain, or pressure in your chest during exercise?

Select Does your heart race or skip beats during exercise?

Select Has a health care provider ever told you that you have: high blood pressure, heart murmur, heart infection, or Kawasaki's disease?

Select Has a health care provider ever ordered a test for your heart (like an ECG or echocardiogram)?

Select Do you have asthma, or has a doctor ever prescribed an inhaler to you?

Select Do you get tired or more short of breath more quickly than your friends during exercise?

Select Do you cough, wheeze, or get short of breath with exercise?

Select Have you had a sprain, strain, broken bone, muscle, tendon or ligament injury **IN THE LAST 6 MONTHS**?

Select Were you born without or are you missing a kidney, an eye, a testicle, spleen, or any other organ?

Select Have you had infectious mononucleosis (mono) **WITHIN THE LAST MONTH**?

Select Have you had a herpes or MRSA **skin** infection?

Select Have you ever had a head injury or concussion?

Select Have you ever been hit in the head and been confused or lost your memory?

Select Have you ever had an unexplained seizure?

Select Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?

Select Have you ever been unable to move your arms or legs after being hit or falling?

Select When exercising in the heat, do you have severe muscle cramps or become ill?

Select Do you wear glasses or contacts or have any other problems with your vision?

CONCERNS

Select Do you have any special concerns today?

If you answered YES to any of the above physical activity questions, please explain:

_____

_____

_____