PEDIATRIC GEMS, PC
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INITIAL HEALTH QUESTIONNAIRE TEENS

(please print)

Name of Patient: _____ D.O.B. _____ M___ F ___
Form Completed by**:** _____Relationship to Patient: _____Date Completed: _____

Medications: include all prescription, nonprescription, maintenance & as needed meds
Name _____ Dose _____ How often ?_____
Name _____ Dose _____ How often ?_____
Other:

Allergies: please specify type, reaction (hives, swelling, etc.), severity (mild, moderate or severe) & interventions (benadryl, epi pen, etc.)
To Medications_____To Food _____Insects, Animals, Other _____

Immunizations: Up-to-date? Yes ___ No ___ PLEASE BRING OR FAX RECORDS.

Birth History:
Problems during the hospital course_____

Development:
Reached milestones at a normal age: Yes___ No___ Not sure ___
Delayed? Yes___ No___; If yes, in what area?_____

History of Childhood Illnesses: No ___Yes ___ *If so, list the date of illness*_____

History of Hospitalizations: No ____ Yes _____ *If yes, please give details.*
Date _____ Location _____ Reason _____
Date _____ Location _____ Reason _____

History of Surgeries: No ____ Yes _____ *If yes, please give details.*
Date _____Surgeon _____Location _____Procedure Performed _____

History of Injuries: No ____ Yes _____ *If yes, please give details.*
Location/Type of Injury _____Circumstances _____Date _____Treatment _____

Prior Screening Tests: (Y/N and results)
Anemia Screening ___Lead Screening ____Tuberculosis ___Prior Allergy Skin Tests ____Hearing ___Vision ___
Psychological Tests __Cholesterol ___

Family Medical History indicate who in relationship to child has the following problems
Gastrointestinal Problems ____High Cholesterol ____Deafness ____Anemia ____Nasal Allergies ____ Liver Disease _____
Asthma ____Kidney Disease ____Bronchitis ____Bedwetting >10yrs old ___Wheezing ____Tuberculosis _____
Epilepsy, Seizures or Convulsions ____Heart Disease <50yrs old ____Heart Attack <50yrs old ____
Blood Pressure <50yrs old ___Alcohol Abuse ____Drug Abuse ____Migraines ___Other Immune Problems ____

Diabetes <50yrs old ____Skin Conditions____Cancer; list type _____

Social History

General:

Parent Information: Married ___ Separated ___ Divorced ___ Single Parent ___
Legal Guardian _____Patient lives with _____
Home Occupants _____Primary Caretaker: Mother ___ Father ___ Other _____
Pets: Yes__ No__; If so, what type & how many? _____Smoking: Yes__ No__; If so, where? _____
Alcohol Use: No ___ Yes ___Drug Use: No ___ Yes ___
Guns in the household: Yes__ No__; If yes, are the guns locked & separate from ammunition? ___

Children >6yrs old:

Name of School _____Grade ____GPA &/or Grades on Last Report Card _____
Problems: _____Child Care after school _____

Adolescent Female History:

Onset of menses __LMP _____Problems _____If >16yrs, have you been taught a self breast exam? ___
Do you perform it monthly? __Have you been to see a Gynecologist? ___ Name of Provider _____
History of Pregnancies _____