adapt
Integrated Health Care

PRIMARY CARE
CHILD-ADOLESCENT HEALTH HISTORY

Patient Name:	**Date of Birth:**	**Age:**	☐ **Male** ☐ **Female**
Current Medical Provider:	Reason for transferring care:		

CURRENT HEALTH

Present Health Concerns:

MEDICATIONS: Please list ALL medications including Vitamins, herbs, home remedies

Medication Name	Strength (mg)	Directions	Reason Taking

ALLERGIES: or reactions to medications, environmental, animals, food, vaccines, etc.

Allergy	Symptoms or Reaction

DENTAL: Has child been seen by a dentist? ☐ Yes ☐ No	If yes, date of last visit:
Name of Dental Provider:	How often seen:
Has child had dental sealants: ☐ Yes ☐ No ☐ Unsure	If yes, when:

IMMUNIZATIONS: Please bring your child's immunization records with you (*If received outside of Oregon*)

Up to date? ☐ Yes ☐ No ☐ Unsure Reactions to past vaccines (if any):

ADOLESCENT HEALTH QUESTIONNAIRE (***for ages 12 and older***) Please have the **PATIENT** answer the questions.

Do you use tobacco or nicotine? ☐ Yes ☐ No ☐ Previously What type:

*In the **last 12 months**, did you:*

Drink any alcohol (more than a few sips)? ☐ No ☐ Yes

Smoke any marijuana or hashish? ☐ No ☐ Yes

Use anything else to get high? ☐ No ☐ Yes

*Have or do you **EVER**:*

Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? ☐ No ☐ Yes

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? ☐ No ☐ Yes

Do you ever use alcohol or drugs while you are by yourself or alone? ☐ No ☐Yes

Do you ever forget things you did while using alcohol or drugs? ☐ No ☐ Yes

Do your family or friends ever tell you that you should cut down on your drinking or drug use? ☐No ☐Yes

Have you ever gotten into trouble while you were using alcohol or drugs? ☐ No ☐ Yes

During the past 2 weeks, have you been bothered by little interest or pleasure in doing things? ☐ No ☐ Yes

During the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless? ☐ No ☐ Yes

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Patient Name:	**Date of Birth:**

MEDICAL HISTORY

Please describe any major medical problems (Asthma, Seizures, Heart Problems, Diabetes, etc.):

Hospitalizations / Surgeries (include year):

Broken Bones or Severe Sprains (include area of body):

Female Patients: (*If applicable*)

Age menstrual period started: First day of last period:

Are you sexually active? ☐ Yes ☐No ☐ Never Contraceptive history:

Infectious Diseases: Has your child had any of the following:

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis
☐ Pertussis (whooping cough) ☐ Other (specify)

PREGNANCY AND BIRTH

Where was your child born:

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:

Birth Weight: Length: Premature: ☐ No ☐ Yes If so, how early:

Delivered by: ☐ Vaginal birth ☐Caesarean If Caesarean, why?

Medical problems during pregnancy:

Medical problems during child's newborn period:

FAMILY / SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship

Child's School: Grade:

Are there any pets in the home? ☐ Yes ☐ No If yes, list:

Does anyone in the home smoke? ☐ Yes ☐ No Who? ☐ Inside ☐ Outside ☐ Car

Please list any sports played or hobbies:

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Patient Name: **Date of Birth:**

FAMILY HEALTH HISTORY

Please indicate with an X family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Angina	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coronary Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Growth / Development Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung / Respiratory Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Melanoma / Skin Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Severe Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weight Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
No / Unknown Family History	☐											

For Office Use Only
Reviewed by Provider (signature): Date: