PEDIATRIC ASSOCIATES

MATURE HEALTH HISTORY (12 YEARS OLD AND UP)

Please complete each section of the patient's health history. ***ALL ITEMS MUST BE COMPLETED.***

PATIENT'S NAME:	PATIENT'S DATE OF BIRTH:	TODAY'S DATE:

MEDICAL HISTORY

Has your child ever had a urinary tract infection? ☐ No ☐ Yes If yes, at what age?

Has your child ever been diagnosed with asthma or wheezing? ☐ No ☐ Yes If yes, at what age?

Has your child ever had any medical problems? ☐ No ☐ Yes If yes, please specify:

Has your child ever had any fractures, concussion, or other serious injuries? ☐ No ☐ Yes If yes, please specify what and at what age?

Does your child have any allergies? ☐ No ☐ Yes If yes, please specify?

Does your child see any specialists? ☐ No ☐ Yes If yes, who?

Has your child ever received occupational, physical or speech therapy(s)? ☐ No ☐ Yes If yes, please specify which therapy(s) and why:

Surgeries or hospitalizations (where the child was admitted to the hospital):

Age: Reason: Age: Reason:

FAMILY HISTORY

Does anyone in your family listed below have any chronic diseases/illnesses such as diabetes, heart attacks, strokes, depression, asthma, cancer or thyroid issues or any other diseases/illnesses we should know about? Please check alive or deceased or other for each family member listed above and if there are no health issues, check healthy.

If unable to complete this section, please let us know why: ☐ Adopted Child ☐ Foster Child ☐ Other _____

Father: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

Mother: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

Sibling: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

Father's Father: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

Father's Mother: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

Mother's Father: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

Mother's Mother: ☐ Alive ☐ Deceased ☐ Healthy ☐ Disease/Illness Explain:

SOCIAL HISTORY

Home situation: ☐ Both Parents ☐ Mother ☐ Father ☐ Adopted ☐ Relative ☐ Foster Care

Parents' marital status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Childcare? ☐ None ☐ Relative ☐ Private Sitter ☐ Daycare

Pets? ☐ No ☐ Yes

Smoke/CO detectors in the home? ☐ No ☐ Yes

Passive smoke exposure? ☐ No ☐ Yes If yes, ☐ Outside? ☐ Inside?

Grade in school: Name of school:

What was the date of your most recent or last tobacco screening?

Vape? ☐ Currently using ☐ Sometimes use ☐ Never used ☐ Patient refused to answer
E-Cigarettes? ☐ Currently using ☐ Sometimes use ☐ Never used ☐ Patient refused to answer
Cigarettes? ☐ Currently using ☐ Sometimes use ☐ Never used ☐ Patient refused to answer