HARVEST PEDIATRICS

NAPA · ST. HELENA

From small acorns **MIGHTY OAKS GROW**

INTERVAL ADOLESCENT HEALTH HISTORY Date:________________________

Name of Patient:	Date of Birth:	Person assisting with this form & relation to patient:

Does your child have a ongoing medical condition (asthma, diabetes)? List diagnosis and age at onset:	☐ No	☐ Yes
Is your child on prescription medicines or over-the-counter medications? List:	☐ No	☐ Yes
Does your child have allergies to medications, pollens or foods? List and indicate reaction:	☐ No	☐ Yes
Does your child have a history of: ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Murmur ☐ Heart Infection	☐ No	☐ Yes
Has your child had an EKG or Echocardiogram (ultrasound of heart)?	☐ No	☐ Yes
Spent the night in a hospital or had surgery?	☐ No	☐ Yes
Suffered a bone, muscle or ligament injury?	☐ No	☐ Yes
Been told they have asthma?	☐ No	☐ Yes
Had a herpes skin infection / skin abcess? When/where?	☐ No	☐ Yes
Born without or now missing a kidney or spleen?	☐ No	☐ Yes
Ever had a seizure?	☐ No	☐ Yes
Had a head injury or concussion?	☐ No	☐ Yes
FAMILY HISTORY		
Has anyone in the family died of no apparent reason or of a heart condition before the age of 50?	☐ No	☐ Yes
Is there a family history of high blood pressure, high cholesterol or diabetes before the age of 50?	☐ No	☐ Yes
Are there members of the family with asthma?	☐ No	☐ Yes
Are there hereditary medical conditions in the family?	☐ No	☐ Yes
PATIENT		
Does your heart skip beats during exercise?	☐ No	☐ Yes
Have you ever had chest pain or pressure that limited your activity?	☐ No	☐ Yes
Have you passed out or nearly passed out during or after exercise?	☐ No	☐ Yes
Do you cough or wheeze after activity?	☐ No	☐ Yes
Have you ever used an inhaler or taken asthma medication?	☐ No	☐ Yes
Do you wear, or have glasses or contacts been prescribed for you?	☐ No	☐ Yes
Have you been hit in the head, confused or lost your memory?	☐ No	☐ Yes
Do you have any rashes or would you like to discuss your acne?	☐ No	☐ Yes
Are you trying to lose or gain weight?	☐ No	☐ Yes
FEMALES ONLY		
Have you ever had a menstrual period?	☐ No	☐ Yes
How old were you when you had your first period?		
How many periods have you had in the last 12 months?		
When was your last period?		