

ESSE HEALTH PEDIATRIC AND ADOLESCENT MEDICINE HEALTH HISTORY

PATIENT NAME: _____

PATIENT BIRTHDATE: _____ Today's date: _____

(THIS SIDE DOES NOT NEED TO BE COMPLETED FOR NEWBORNS)

PAST MEDICAL HISTORY	Are immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child take any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list):	(please provide record of prior vaccines)
1	Other concerns you have?
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Has your child ever had the following?	Physician's comments:
Chicken pox disease <input type="checkbox"/> Yes	
Eye or vision problems <input type="checkbox"/> Yes	
Ear or hearing problems <input type="checkbox"/> Yes	
Dental problems <input type="checkbox"/> Yes	
Speech problems <input type="checkbox"/> Yes	
Recurrent sore throat or tonsillitis <input type="checkbox"/> Yes	
Bronchitis/pneumonia <input type="checkbox"/> Yes	
Wheezing or asthma <input type="checkbox"/> Yes	
Allergies <input type="checkbox"/> Yes	
Frequent runny nose <input type="checkbox"/> Yes	
Recurrent nosebleeds <input type="checkbox"/> Yes	
Recurrent skin rashes or eczema <input type="checkbox"/> Yes	
Anemia or bleeding problems <input type="checkbox"/> Yes	
Stomach or bowel problems <input type="checkbox"/> Yes	
Hernia <input type="checkbox"/> Yes	
Bedwetting/soiling <input type="checkbox"/> Yes	
Urine/kidney problems or infections <input type="checkbox"/> Yes	
Heart condition <input type="checkbox"/> Yes	
High blood pressure <input type="checkbox"/> Yes	
Fainting spells <input type="checkbox"/> Yes	
Joint pain or swelling <input type="checkbox"/> Yes	
Bone problems/fractures/scoliosis <input type="checkbox"/> Yes	
Headaches <input type="checkbox"/> Yes	
Convulsions/seizures <input type="checkbox"/> Yes	
School problems <input type="checkbox"/> Yes	
ADD/Learning disabilities <input type="checkbox"/> Yes	
Mental health problems <input type="checkbox"/> Yes	
Discipline issues <input type="checkbox"/> Yes	
Trouble getting along with others <input type="checkbox"/> Yes	
Restless, fidgety or destructive behavior <input type="checkbox"/> Yes	
Nervousness or unusual fears <input type="checkbox"/> Yes	
Depression or extreme sadness <input type="checkbox"/> Yes	
History of tobacco/drug/alcohol use <input type="checkbox"/> Yes	
History of sexual activity <input type="checkbox"/> Yes	
History of sexual abuse <input type="checkbox"/> Yes	
History of physical abuse <input type="checkbox"/> Yes	
Sleep problems <input type="checkbox"/> Yes	
Has your daughter started her period? <input type="checkbox"/> Yes	
Age at onset: _____	
Menstrual problems? <input type="checkbox"/> Yes	