Date:

CABOT MEDICAL CARE HEALTH HISTORY- PEDIATRIC

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**
Please list any other physicians who follow your care and why they see you:	

PERSONAL HEALTH HISTORY

Immunizations up to date? ☐ Yes ☐ No		**Had Chicken Pox Disease?** ☐ Yes Date:_____ ☐ No
Immunizations and dates (12 years and older)	☐ Tetanus	☐ Meningitis
	☐ Hepatitis A	☐ Gardasil:
	☐ Influenza	☐ Other:

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Birth History:

Please turn to next page

List all prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.							
Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Tobacco and Alcohol	Is there tobacco use?				☐ Yes	☐ No	
	Does anyone else in the home smoke?				☐ Yes	☐ No	
	Has there been any alcohol use?				☐ Yes	☐ No	
	Has there been illicit drug use?			☐ Never	☐ Remotely	☐ Other	
Social History	Who currently lives in the home?						
	List kinds of pets:						
	Daycare?				☐ Yes	☐ No	
	Home Schooled?				☐ Yes	☐ No	
	In what grade is your child?						
	Are there any behavioral problems?						
	Does your child struggle with grades or require special assistance?				☐ Yes	☐ No	
	Extracurricular Activities:						

Name *(Last, First, M.I.):*	**DOB:**

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Grandmother *Maternal*		
Grandfather *Maternal*		
Grandmother *Paternal*		
Grandfather *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

GIRLS ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Any pregnancies?	☐ Yes	☐ No

LAB

Approximate date of most recent lab done:		
What lab was done?	☐ Normal	☐ Abnormal

DR NOTES

DOCTOR SIGNATURE: _____ DATE: _____