Sunrise Family Clinic

Adolescent/Pediatric History

Name: _____

Date: _____

Main reason for today's visit: _____

Other concerns: _____

_____

List all MEDICATIONS AND SUPPLEMENTS (eg. vitamins, over the counter medications) or attach list:

□ **NONE**

NAME and STRENGTH	REASON taken	FREQUENCY taken

Pharmacy: _____

ALLERGIES: □ NONE KNOWN

ALLERGY	REACTION

IMMUNIZATIONS:

Were all immunizations completed in Oregon? □ Yes □ No

If no, what state were they completed in? _____ *Please bring a copy of immunization card as soon as possible, so we can update the Oregon State Database with out of state immunizations.*

Up to date, as far as you are aware, on all immunizations? □ Yes □ No

Date of last physical exam or well child check: _____

Females only:

Date of most recent menstrual period: _____ (or □ no menses yet)

Age at first menstrual period: _____

Trouble with menses? □ No □ Yes (□ heavy □ irregular □ painful)

MEDICAL HISTORY: Have you ever had any of the following?

No	Yes		No	Yes		No	Yes	
□	□	ADD/ADHD	□	□	Eating Disorder	□	□	Lung Disease
□	□	Allergies	□	□	Fibromyalgia	□	□	Mental health problem
□	□	Anemia	□	□	GI Problems	□	□	Muscle, Joint, or Bone Problems
□	□	Anxiety Disorder	□	□	Neurological problems	□	□	Head Injury/Concussion
□	□	Inherited/Genetic Disease	□	□	Reflux/GERD	□	□	Thyroid Problems
□	□	Asthma	□	□	Headaches/Migraines	□	□	Problems with blood
□	□	Birth Defects	□	□	Heart Problems/Murmur	□	□	Pulmonary Embolism
□	□	Cancer (Type_____)	□	□	Hepatitis	□	□	Seizures/Epilepsy
□	□	High Cholesterol	□	□	Skin Problems	□	□	Developmental Problems
□	□	Depression	□	□	Hypertension	□	□	Sleep apnea
□	□	Diabetes	□	□	Kidney/Bladder Issues	□	□	Tuberculosis
□	□	Ear or Hearing Problems	□	□	Liver Disease	□	□	Vision or Eye Problems

Specifics of problems or other: _____

_____

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Date: _____

SURGICAL HISTORY:

SURGERY	REASON	YEAR

FAMILY HISTORY:

Relation	Alive	Age	Health Issues (Cancer, heart disease, diabetes, stroke, high blood pressure, heart attack, asthma, genetic issues, etc.)
Mother	Yes/No		
Father	Yes/No		
Grandmother (maternal)	Yes/No		
Grandfather (maternal)	Yes/No		
Grandmother (paternal)	Yes/No		
Grandfather (paternal)	Yes/No		
Brother/Sister	Yes/No		
Brother/Sister	Yes/No		
Brother/Sister	Yes/No		
Other _____	Yes/No		
Other _____	Yes/No		

SOCIAL HISTORY:

Home situation (please indicate all in household): □ Both parents □ Mother □ Father □ Relatives □ Foster parents □ Sibling(s) age(s): _____ □ Other _____

Year in school (circle): Pre-K Kinder 1 2 3 4 5 6 7 8 9 10 11 12 College

Diet: □ Regular □ Vegetarian □ Vegan □ Gluten free □ Low Carb □ Cardiac □ Diabetic □ Other _____

Caffeine intake: □ None □ Occasional □ Moderate □ Heavy

Exercise level: □ None □ Occasional □ Moderate □ Heavy

Hobbies/Sports: _____

Stress level: □ Low □ Medium □ High

Recent changes at home or school? □ Yes □ No

Smoking status: □ Current smoker (amt _____) □ Former smoker (quit date _____) □ Never smoker

Does anyone at home smoke? □ No □ Yes (who? _____ outside? _____)

Alcohol use: □ Heavy (amt _____) □ Moderate (amt _____) □ Occasional □ Never

Marijuana and other drug use: □ Never used □ Current use (drug(s): _____ □ daily □ weekly □ rarely)
□ Former use (drug(s): _____ quit date: _____)

Sexual activity: □ Currently* □ Formerly, not now* □ Never *Birth control method? _____

Would you like to talk about any of the following?

□ Feeling sad or anxious □ Help with drugs or alcohol □ Diet and exercise □ Healthy weight loss

□ Quitting smoking □ Feeling unsafe (and bullying) □ Birth control or concern about STDs

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Name: _____

Date: _____

Have you/your child or teen *recently* had any of the following (circle/underline all that apply)?

Constitutional

excess weight gain , excess weight loss , loss of appetite , fever , fussy , diminished activity , fatigue

Eyes

eye pain , blurry vision , eye redness , eye itchiness , eye swelling , eye discharge

ENMT

ear pain , ear discharge , hearing loss , sinus pressure , drooling , facial swelling , congestion , sore throat , hoarseness , foul smelling breath , mouth lesions

Cardiovascular

chest pain , rapid heart rate

Chest/Breasts

lumps , tenderness , discharge

Respiratory

cough , bark-like cough , wheezing , chest tightness , pain with respiration , noisy breathing , rapid respirations , difficulty breathing

Gastrointestinal

difficulty swallowing , abdominal pain , nausea , vomiting , diarrhea , constipation , blood in stools , mucus in stool

Genitourinary

discharge , blood in urine , pain with urination , increased frequency of urination , voiding urgency , testicular pain , swelling , redness , itching , masses , bedwetting/accidents

Musculoskeletal

soft tissue swelling , joint swelling , myalgia , limited motion , previous injuries , trauma

Skin

pain , itchiness , dry skin , flaking , redness , rash , diaper rash , hives , skin lesions , skin growths , skin lumps , bruising , insect bites

Neurological symptoms

numbness , weakness , tingling , burning , shooting pain , headache , dizziness , loss of conciousness

Psychiatric

depression , anxiety , insomnia , stress , loss of interest

Endocrine

increased thirst , increased drinking , temperature intolerance

Allergic/Immunologic

sneezing , runny nose

Other: Please list

□ None of the above

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

Sunrise Family Clinic

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/16)