HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

Pediatric/Adolescent Health History Intake Form

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____Date of Birth: _____ Age: _____Sex: _____ Today's Date: _____

PRENATAL HISTORY

A. Mother's Pregnancy: □Normal □Complications:_____
B. Gestation:_____weeks
C. Birth Location: □Hospital □Birthing Center □Home □Other_____
D. Delivery: □Vaginal □C-Section □Induced - Complications: □No □Yes_____
E. Birth Weight:_____lbs_____oz _____Length:_____inches

PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

1. _____
2. _____
3. _____
4. _____

PAST MEDICAL HISTORY

MEDICATIONS: Please list all medication + over the counter medications that your child is taking with dosages.

1. _____ 4. _____
2. _____ 5._____
3. _____ 6._____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1. _____ 4. _____
2. _____ 5._____
3. _____ 6._____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____
2. Environment: _____
3. Food: _____

PO Box 490, 120 Jackson River Road, Monterey, VA 24465
Phone 540-468-3300 - Fax 540-468-3301

Last Name:_____First Name:_____Date of Birth:_____

IMMUNIZATIONS

Please place an **X** next to each vaccination that your child has received. Please provide our office with a current vaccination history.

	Hepatitis A		Measles
	Hepatitis B		Mumps
	Diphtheria		Rubella
	Pertussis		Varicella (Chicken Pox)
	Tetanus		Influenza
	Haemophilus Influenza Type B		Rotovirus
	Polio		Human Papilloma Virus (HPV)
	Pneumococcal		

Has your child ever had a reaction to an immunization? □ Yes □ No

If so, which vaccine and what was the reaction:_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age	Ear Infections:	No	Yes/Age
ADD:	No	Yes/Age	Eating Disorders:	No	Yes/Age
ADHD:	No	Yes/Age	Eczema:	No	Yes/Age
Alcohol use:	No	Yes/Age:	Headaches:	No	Yes/Age
Allergies:	No	Yes/Age	Head lice:	No	Yes/Age
Asthma:	No	Yes/Age	Mononucleosis:	No	Yes/Age
Bedwetting:	No	Yes/Age	Obesity/Overweight:	No	Yes/Age
Behavior problems:	No	Yes/Age	Pink eye:	No	Yes/Age
Bronchitis	No	Yes/Age	Pneumonia:	No	Yes/Age
Colic:	No	Yes/Age	Colds:	No	Yes/Age
Constipation:	No	Yes/Age:	Sinus Infection:	No	Yes/Age
Cough:	No	Yes/Age:	Thrush:	No	Yes/Age
Croup:	No	Yes/Age	Vomiting:	No	Yes/Age
Depression/ Anxiety	No	Yes/Age	Whooping cough:	No	Yes/Age
Diaper Rash:	No	Yes/Age:	Other Illness:		Age
Diarrhea	No	Yes/Age:	Other Illness:		Age
Drug Abuse	No	Yes/Age:			

Please comment on any illnesses indicated above: _____

_____

_____

_____

Last Name:_____ First Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS:

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

SURGERIES:

Type of Surgery	Date
_____	_____
_____	_____
_____	_____

LABS AND EXAM HISTORY:

Date of last well child check:_____ Date of last blood work: _____

Date of last urine test:_____ Date of last EKG:_____

Female Adolescents:

Date of last PAP and pelvic exam: _____

SOCIAL HISTORY

Parent's Marital Status:

□ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Living With:

□ Both Parents □ Mother □ Father □ Grandparents □ Foster Family □Other_____

Siblings (Indicate names and ages)

1. _____ 2. _____

3. _____ 4._____

5. _____ 6._____

Mother's Occupation: _____ Father's Occupation: _____

Guardian's Occupation:_____

Daycare Location:_____Days/Hours per week: _____

Last Name:_____First Name:_____Date of Birth:_____

SOCIAL HISTORY

NUTRITIONAL HISTORY:

Infant/Toddlers:

Type: □Nursing □Formula/Specify _____ □Both

Duration: □<15 min □15-30 min □30-45 min □45-60 min

Frequency: □Every hour □Every other hour □Every 3 hours □Every 4 hours □Every 5 hours

Amount of formula per feeding: □<1oz □1-2oz □2-3oz □3-4oz □>4oz

Have you started solids yet? If so what type _____

How much juice does your infant/toddler drink in a day _____ water _____

What type of milk does your child drink _____ How much per day _____

School Agers/Adolescents:

What is a typical breakfast_____

What is a typical lunch _____

What is a typical dinner _____

What are typical snacks _____

How many glasses of water do you drink each day _____

Do you have any special dietary restrictions _____

EXERCISE:

Do you exercise regularly? □ Yes □ No

What type/activity_____ How long _____How Often_____

SLEEP:

How many hours of sleep do you get at night on average _____

Do you have trouble falling asleep? □ No □ Yes/Why _____

How often do you wake up in the middle of the night and for what reasons _____

_____

Do you have trouble waking up? □ No □ Yes/Why _____

Do you feel rested when you wake up? □ Yes □ No/Why_____

ENERGY AND STRESS:

Adolescents:

How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?

How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?

How do you cope with stress?

TRAVEL HISTORY:

Identify any domestic or foreign travel and indicate year of travel:

Place: _____Year _____ Place: _____Year:_____

Last Name:_____ First Name:_____ Date of Birth:_____

SOCIAL HISTORY – School agers/Adolescents Only

SUBSTANE USE:
Identify any substances you have used and circle whether in the past (P) or are currently using (C)

Soda:	P	C	Freq:_____	Tobacco:	P	C	Type/Freq_____
Coffee:	P	C	Freq: _____	Recreational Drugs:	P	C	Type/Freq_____
Alcohol:	P	C	Freq:_____	Other:	P	C	Type/Freq _____

BIRTH CONTROL:
Are you sexually active with □ Men □ Women □ Both
What form of contraception/birth control are you using (Check all that apply).
□ Withdrawal □ Condom □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch
□Fertility Awareness Method □ The Sponge □ Spermicide □ Diaphragm □ Cervical Cap
□ None

FAMILY HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to your family members.

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Eczema							
Epilepsy							
Headaches							
Heart Disease							
Hepatitis							
High Blood							
Kidney Disease							
Stroke							
Tuberculosis							