Patient Centered Care, PLL-C
PEDIATRIC HEALTH HISTORY

Today's Date: _____

Name: _____ **Age:** _____ **Birth Date:** _____

Living Situation: Parent _____ Guardian ____ Grand-Parents ____ Other ____

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____
_____
_____

Please list any allergies you have to food or medications: _____
_____

Please list any medical problems that you are currently being treated for or have been treated for in the past: _____
_____
_____
_____

Please list any surgeries that you have had including the date: _____
_____
_____
_____

Please list any medications, prescription or over-the-counter, that you take: _____
_____
_____
_____

Do parents, grandparents, brothers, or sisters have any of the following? (Check all that apply)
___ADD ___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____
___ Stroke ___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery

Age of first period: ____ Date of last period: _____ Date of last Pap smear: _____ Result: _____

Are you sexually active? ____ YES ____ NO With males, females, or both? _____

If you are sexually active, what is your method of contraception? _____

Do you get routine physical exercise? ___ YES ___ NO If yes, what type & how long? _____

Does anyone in your home use tobacco products? ___ YES ___ NO

Do you drink alcohol? ___ YES ___ NO If yes, how much per day? _____ What type? _____

Do you drink caffeine products? ___ YES ___ NO If yes, how much per day? _____ What type? _____