



LANCASTER PEDIATRIC ASSOCIATES, LTD.

Medical History Form- Yearly Update Patients 12 years & older

Patient's First/Last Name: _____ Birthdate _____

Age _____ Date _____

Please list the following: (Nurses, please enter under the "Basic Information" tab)

Primary Language:

Race: Declined to specify (circle)

Ethnicity: Declined to specify (circle)

Please review questions 5 & 6 under Academic & Social History and answer both for this year

Patient Medical History

In the past YEAR have any of the following occurred?

1. Hospitalizations? (list month, hospital and reason for hospitalization) None

2. Surgeries? (list month, hospital and surgery performed) None

3. Please list any serious injuries or accidents? (list month and nature of injury/accident) None

4. Any new drug, food or environmental allergies? Yes No (if yes list below with reaction)

5. **For girls:** Has she started her menstrual periods? Yes No Are there problems with her periods? Yes No

6. Does your child see a dentist? Yes No If yes, who: _____ Date of last visit: _____

Please **CIRCLE** any condition that is **NEW** in the past year:

Chicken pox

If Yes When? _____

Eye conditions/corrective lenses

Problems with ears or hearing

Thyroid or other endocrine problems

Chronic or recurrent skin problems (acne, eczema) Bladder, kidney infections or other urologic problems

Seizures or other neurologic problems

Behavior disorders (ADD, ADHD, ODD)

Mental health concerns

Emotional problems or suicide attempts

Drug or alcohol use

Cancer

Blood transfusion

Anemia or bleeding problem

Constipation requiring office visits

Frequent abdominal pain or GERD

Diabetes

Frequent headaches

Chronic/serious lung disease

High blood pressure

High cholesterol

Sexually transmitted infection

Other:

Please explain any conditions you circled above or explain any other medical conditions:

Patient's First/Last Name: _____ Birthdate _____

Patient Academic & Social History

Academic & Social History update over the last YEAR—Please Print

1. Has your child had any difficulties with academics? Yes No
2. Has he/she been placed in a special resource class? Yes No
3. Did he/she need to repeat last year's grade? Yes No
4. Has your child been diagnosed with a learning disorder within the last year? Yes No
5. Has your child displayed any signs of social isolation or social anxiety in the last year? Yes No *
6. Has your child experienced any issues with bullying in the last year? Yes No *

If you marked "yes" to 5 or 6, please hand your form directly to the nurse or to the provider that is seeing your child today

Please explain any "yes" answers further:

Household Structure

List the name anyone CURRENTLY LIVING IN THE HOUSEHOLD- include any parents, siblings , any extended family, step-family, grandparents, others	Date of Birth	Relationship to Child

What is the current family parental structure for the patient:

1.Parent's Marital Status: Married, living together Divorced Not applicable/other(please explain below)

2.Patient's custody status: Joint Visitation Non-custodial (If visitation, or non-custodial please explain below)

Patient's First/Last Name: _____ Birthdate _____

Household Environment

Please answer the following environmental questions:

1. Does anyone in the household smoke? Yes No
2. Are there firearms in the home? Yes No
If yes, are the guns locked and kept separate from the ammunition? Yes No
3. Are there any pets in the home? Yes No
If yes, what type?
4. In the last year, have you worried that the food you purchased would run out before you had money to buy more? Yes No Declined to Answer
5. In the last year, did you run out of food and not have money to purchase more?
Yes No Declined to Answer

If you answered “**yes**” to the **two questions above**, would you like information on community resources that can help?

Yes No Not applicable

No changes since completion of last medical history form

Patient's First/Last Name: _____ Birthdate _____

Changes to Family History in the past YEAR— check all that apply. ONLY include GENETIC family members.

(If no changes, leave blank)

	Mom	Dad	Sister	Brother
Cancer				
Asthma/Other Lung Disease				
Diabetes or Other Endocrine Problems (before 50 years old)				
High Blood Pressure				
High Cholesterol				
Heart Disease (before 50 years old)				
Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)				
Kidney Disease				
Liver Disease				
Bleeding Disorder				
Mental Illness				
Epilepsy, Convulsions, or Seizures				
Neurologic Disorder				
ADHD/ADD				
Alcohol Abuse				
Drug Abuse				
Hearing Problems/Deafness				
Vision Impairment/Eye Disorder (not including standard glasses or contacts)				
Immune Problems, Recurrent Infections, or HIV/AIDS				
Other GI Disease/Disorder				
Unexplained Sudden Death (before 50 years old)				

If no significant family history, please check here:

Additional Pertinent Conditions

Explain _____
