WELCOME TO
Lakeside Primary Care

In order to us to get to know you and your health care needs, please fill out the following form to the best of your ability. Our goal is to provide you with exceptional health care, and it starts with getting to know you.

Please let us know how you heard about our practice. Check all the ways that we have caught your attention.

Billboards _____ Website _____
Magazine ads _____ Personal referral _____
Mailing _____ Google search _____
Previous patient of the physician_____ Commercial _____
Other _____

MEDICAL HEALTH HISTORY AGES 11-18

CHILD'S NAME: _____ Date of Birth: _____ AGE: _____

Mother's Name: _____ Age: ____ Occupation: _____

Father's Name: _____ Age: ____ Occupation: _____

Legal Guardian's Name: _____

Please circle the best response:

Race Information: White Black/African American Asian Alaskan Native American

Pacific Islander Hispanic/Latino Non-hispanic Latino More than one race I prefer not to disclose

Has your child's development been normal? Y ___ N ___

Explain:_____

_____

_____

CHILD'S PAST MEDICAL HISTORY

PLEASE PLACE AN "X" IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

	ACID REFLUX		**ENLARGED TONSILS**		**PALPITATIONS**
	ADHD		**ENLARGED ADENOIDS**		**POOR HEARING**
	ALLERGIES		**FATIGUE**		**POOR VISION**
	ANEMIA		**HEADACHE**		**POOR WEIGHT GAIN**
	ANXIETY		**HEART MURMUR**		**PREMATURITY**
	ASTHMA		**HEMORRHOIDS**		**RECURRENT EAR INFECTIONS**
	BACK PAIN		**HIGH CHOLESTEROL**		**SEIZURES**
	BRONCHIOLITIS		**HIGH BLOOD PRESSURE**		**SEXUALLY TRANSMITTED DISEASE**
	CHICKEN POX		**HYPOTHYROIDISM**		**SLEEP APNEA**
	CONSTIPATION		**IRRITABLE BOWEL DISEASE**		**STRABISMUS**
	DEPRESSION		**JUVENILE RHEUMATOID ARTHRITIS**		**URINARY TRACT INFECTIONS**
	DIABETES – JUVENILE		**LOSS OF WEIGHT**		**WHEEZING**
	DIABETES TYPE 2		**MIGRAINES**		**OTHER:**
	DRUG ABUSE		**OBESITY**		**OTHER:**

CHILD'S ALLERGIES: _____

_____

CHILD'S MEDICATIONS (INCLUDE NAME / /DOSE / HOW TAKEN)

_____

_____

_____

CHILD'S HOSPITALIZATIONS (Reason) ***DATE***

_____ _____

_____ _____

_____ _____

CHILD'S SURGERIES (Date)

Addenoidectomy _____ Pyloric Stenosis Repair _____

Appendectomy _____ Tonsillectomy _____

Endoscopy _____ Tonsils and adenoids _____

Inguinal hernia repair _____ Tubes in ears _____

Umbilical hernia repair _____ Other _____

CHILD'S SOCIAL HISTORY

Lives with : Parents ___ Mother ___ Father ___ Stepfather ___ Stepmother ___ Sisters ___

Brother ___ Half Siblings ___ Grandparent ___ Other _____

Siblings names and ages: _____

Shared Custody: With dad one day per wk/weekends ___ With mom one day per wk/weekends ___

Other _____

Childcare: Parents ___ Family ___ Daycare ___

Smoking status if 11 years or older: Tobacco ___ Snuff ___ Chew ___ None ___

Smokers in the home: No ___ Yes ___ Outside Only ___

Exercise: Sports ___ Other adequate ___ Inactive ___

Weapons in the home: No ___ Yes ___

Driving: No ___ Yes ___

Pets: None ___ Dog ___ Cat ___ Fish ___ Other _____

Water: City ___ Well ___ Flouride ___

TV/Computer time daily: <2hrs ___ >2hrs ___

Grade: _____

Grades: Good ___ Fair ___ Poor ___

School Problems: None ___ Behvaioral ___ Bullying ___ Attendance ___

Plans After High School: College ___ Military ___ Trade ___ School ___ Undecided ___

CHILD'S FAMILY HISTORY (Any family member /relative including mother, father, mother's parents, father's parents, brother or sister)

Illness ***Family Member/Relative who has illness***

Allergies/Sinusitis _____

Asthma _____

Lung disease _____

Birth Defects _____

Blood Disorders _____

Bone/Joint Disorders _____

Cancer _____

Leukemia _____

Eye Disorders _____

Ear Disorders _____

Diabetes _____

Thyroid Disease _____

Heart Disease _____

High Blood Pressure _____

High Cholesterol _____

Kidney Disease _____

Mental Retardation/Delay _____

Muscle Disease/Multiple Sclerosis _____

Muscular Dystrophy _____

Psychiatric Disorders _____

Seizures _____

Cerebral Palsy _____

Stomach Disease or Ulcers _____

Colitis _____

Other _____

Female Patients Please Complete:

AGE MENSTRUAL CYCLE BEGAN**:** _____ FREQUENCY: _____

LENGTH OF PERIODS: _____ LAST MENSTRUAL PERIOD: _____

PREGNANCIES**:** _____ BIRTHS**:** _____ MISCARRIAGES**:** _____

DO YOU USE BIRTH CONTROL? _____ WHAT METHOD? _____

Thank you for completing all of the requested information. We look forward to getting to know you and taking care of you in an environment that is designed with your health care needs in mind.