WASHINGTON HEALTH SYSTEM
Primary Care - Lakeside

MEDICAL HEALTH HISTORY AGES 11-18

In order for 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.

Child's Name:_____ Date Of Birth:_____ Age:_____

Mother's Name:_____Age:_____Occupation:_____

Father's Name:_____Age:_____Occupation:_____

Legal Guardian's Name:_____

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

Billboards_____ **Website_____** **Radio Commercial_____**

Magazine ads_____ **Google search_____** **Insurance Company_____**

Mailing _____ **Personal referral_____** **Previous patient of the physician_____**

Other – Please tell us where: _____

Our organization takes care of people with different needs and we make every attempt to make all feel comfortable and welcome. During the registration process you will be asked questions about information that may impact your health care, including Race, Ethnicity, Sex and Sex at Birth.

Please circle the best response:

Race Information (Please circle): White Black/African American Asian Alaskan or Native American Hawaiian or Pacific Islander Hispanic/Latino More than one race I prefer not to disclose

Has your child's development been normal? Yes_____ No_____

What was the gender on your child's birth certificate? Please circle: Male Female Unknown

Sexual orientation (PLEASE CHECK):		Gender identity (PLEASE CHECK):	
Lesbian, Gay, or Homosexual		Male	
Straight or Heterosexual		Female	
Bisexual		Female to Male/Transgender Male	
Do Not Know		Male to Female/Transgender Female	
Choose Not to Disclose		Genderqueer; neither exclusively male	
Something else; describe		Choose not to Disclose	
		Other category;	

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CHILD'S PAST MEDICAL HEALTH HISTORY

WHAT MEDICATION IS YOUR CHILD CURRENTLY TAKING? (PLEASE INCLUDE NAME AND DOSAGE)

PLEASE CHECK BOX TO THE RIGHT IF YOUR CHILD HAS OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

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

IS YOUR CHILD ALLERGIC TO ANYTHING?
(PLEASE LIST ALL ALLERGIES-MEDICATIONS, DYES, ENVIRNOMENTAL, TAPE, ETC… AND THE REACTION IT CAUSES)

CHILD'S HOSPITALIZATIONS REASONS:

REASON	DATE

CHILD'S SURGERIES:

SURGERY	DATE	SURGERY	DATE
ADDENOIDECTOMY		PYLORIC STENOSIS REPAIR	
APPENDECTOMY		TONSILLECTOMY	
ENDOSCOPY		TONSILS AND ADENOIDS	
INGUINAL HERNIA REPAIR		TUBES IN EARS	
UMBILICAL HERNIA REPARE		OTHER:	

CHILD'S SOCIAL HISTORY

CHILD LIVES WITH:

PARENTS		STEPMOTHER		GRANDPARENT	
MOTHER		SISTERS		OTHER:	
FATHER		BROTHER		OTHER:	
STEPFATHER		HALF SIBLINGS			

SIBLINGS NAMES AND AGES:

SHARED CUSTODY:

With dad one day per week/weekends:	
With mom one day per week/weekends:	
Other:	

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Please place and "X" by the best response noted in the categories below:

Childcare provided by:

- Parents _____
- Family _____
- Daycare _____

Smoking status if 11 years or older:

- Tobacco _____
- Snuff _____
- Chew _____
- None _____

Smokers in the home:

- No _____
- Yes _____
- Outside Only_____
- Smoke Detectors in the home? No_____ Yes_____

Exercise:

- Sports _____
- Other adequate_____
- Inactive _____

Weapons in the home:

- No _____
- Yes _____
- Guns Locked? No _____ Yes _____

Driving:

- No _____
- Yes _____

Pets:

- None _____
- Dog _____
- Cat_____
- Fish_____
- Other_____

Water:

- City _____
- Well _____
- Fluoride _____

TV/Computer time daily:

- Less than 2 hours _____
- Greater than 2 hours _____

Grade Level in School: _____

Grades:

- Good _____
- Fair _____
- Poor _____

School Problems:

- None _____
- Behavioral _____
- Bullying _____
- Attendance _____

Plans after High School:

- College _____
- Military _____
- Trade School _____
- Undecided_____

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CHILD'S FAMILY HISTORY

PLEASE COMPLETE TABLE INDICATING MEDICAL HISTORY OF FAMILY MEMBERS TO THE BEST OF YOUR KNOWLEDGE:

	Allergies/Sinusitis	Asthma	Birth Defects	Blood Disorders	Bone Joint Disorders	Cancer	Cerebral Palsy	Colitis	Diabetes	Ear Disorders	Eye Disorders	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Leukemia	Lung Disease	Mental Retardation/Delay	Muscle Disease/ Multiple Sclerosis	Muscular Dystrophy	Psychiatric Disorders	Seizures	Stomach Disease or Ulcers	Thyroid Disease
Father																								
Mother																								
Sister																								
Brother																								
Paternal Grandfather																								
Paternal Grandmother																								
Maternal Grandfather																								
Maternal Grandmother																								

HAVE YOU HAD ANY OF THE FOLLOWING IMMUNIZATIONS?

INFLUENZA (FLU)	NO	YES	UNSURE	DATE:
PNEUMONIA	NO	YES	UNSURE	DATE:
TDAP (Tetanus, Diphtheria, and Cellular Pertussis)	NO	YES	UNSURE	DATE:
HEPATITIS B	NO	YES	UNSURE	DATE:
HPV (GARDASIL)	NO	YES	UNSURE	DATE:
MENINGOCOCCAL	NO	YES	UNSURE	DATE:
COVID	NO	YES	Manufacture	DATE:

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Female Patients Please Complete the Following:

- AGE MENSTRUAL CYCLE BEGAN: _____
- FREQUENCY OF MENSTRUAL PERIODS: _____
- LENGTH OF PERIODS: _____
- LAST MENSTRUAL PERIOD: _____
- PREGNANCIES: _____
- BIRTHS: _____
- MISCARRIAGES: _____

Do You Use Birth Control? _____

What Method? _____

Thank-you for completing all 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.

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