

**PEDIATRIC GEMS, PC**  
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**INITIAL HEALTH QUESTIONNAIRE TEENS**

(please print)

Name of Patient: \_\_\_\_\_ D.O.B. \_\_\_\_\_ M \_\_\_ F \_\_\_  
Form Completed by: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**Medications:** include all prescription, nonprescription, maintenance & as needed meds

Name \_\_\_\_\_ Dose \_\_\_\_\_ How often ? \_\_\_\_\_  
Name \_\_\_\_\_ Dose \_\_\_\_\_ How often ? \_\_\_\_\_  
Other: \_\_\_\_\_

**Allergies:** please specify type, reaction (hives, swelling, etc.), severity (mild, moderate or severe) & interventions (benadryl, epi pen, etc.)

To Medications \_\_\_\_\_ To Food \_\_\_\_\_ Insects, Animals, Other \_\_\_\_\_

**Immunizations:** Up-to-date? Yes \_\_\_ No \_\_\_ PLEASE BRING OR FAX RECORDS.

**Birth History:**

Problems during the hospital course \_\_\_\_\_

**Development:**

Reached milestones at a normal age: Yes \_\_\_ No \_\_\_ Not sure \_\_\_  
Delayed? Yes \_\_\_ No \_\_\_; If yes, in what area? \_\_\_\_\_

**History of Childhood Illnesses:** No \_\_\_ Yes \_\_\_ *If so, list the date of illness* \_\_\_\_\_

**History of Hospitalizations:** No \_\_\_ Yes \_\_\_ *If yes, please give details.*

Date \_\_\_\_\_ Location \_\_\_\_\_ Reason \_\_\_\_\_  
Date \_\_\_\_\_ Location \_\_\_\_\_ Reason \_\_\_\_\_

**History of Surgeries:** No \_\_\_ Yes \_\_\_ *If yes, please give details.*

Date \_\_\_\_\_ Surgeon \_\_\_\_\_ Location \_\_\_\_\_ Procedure Performed \_\_\_\_\_

**History of Injuries:** No \_\_\_ Yes \_\_\_ *If yes, please give details.*

Location/Type of Injury \_\_\_\_\_ Circumstances \_\_\_\_\_ Date \_\_\_\_\_ Treatment \_\_\_\_\_

**Prior Screening Tests:** (Y/N and results)

Anemia Screening \_\_\_ Lead Screening \_\_\_ Tuberculosis \_\_\_ Prior Allergy Skin Tests \_\_\_ Hearing \_\_\_ Vision \_\_\_  
Psychological Tests \_\_\_ Cholesterol \_\_\_

**Family Medical History** indicate who in relationship to child has the following problems...

Unremarkable (Please select this if all answers below are no) \_\_\_\_\_  
Gastrointestinal Problems \_\_\_\_\_ High Cholesterol \_\_\_\_\_  
Deafness \_\_\_\_\_ Anemia \_\_\_\_\_  
Nasal Allergies \_\_\_\_\_ Liver Disease \_\_\_\_\_  
Asthma \_\_\_\_\_ Kidney Disease \_\_\_\_\_  
Bronchitis \_\_\_\_\_ Bedwetting >10yrs old \_\_\_\_\_  
Wheezing \_\_\_\_\_ Epilepsy, Seizures or Convulsions \_\_\_\_\_  
Mental Illness \_\_\_\_\_ Autism \_\_\_\_\_  
Heart Disease <50yrs old \_\_\_\_\_ Alcohol Abuse \_\_\_\_\_  
Heart Attack <50yrs old \_\_\_\_\_ Drug Abuse \_\_\_\_\_  
Blood Pressure <50yrs old \_\_\_\_\_ Genetic Disorders \_\_\_\_\_  
Migraines \_\_\_\_\_ Other Immune Problems \_\_\_\_\_  
Diabetes <50yrs old \_\_\_\_\_ Skin Conditions \_\_\_\_\_  
Cancer; list type \_\_\_\_\_

**Social History**

**General:**

Parent Information: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single Parent \_\_\_

Legal Guardian \_\_\_\_\_

Pets: Yes\_\_ No\_\_; If so, what type & how many? \_\_\_\_\_

Smoking: Yes\_\_ No\_\_; If so, where? \_\_\_\_\_

Alcohol Use: No \_\_\_ Yes \_\_\_ Drug Use: No \_\_\_ Yes \_\_\_

Guns in the household: Yes\_\_ No\_\_; If yes, are the guns locked & separate from ammunition?

\_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

GPA &/or Grades on Last Report Card \_\_\_\_\_

Problems: \_\_\_\_\_

**Adolescent Female History:**

Onset of menses \_\_\_\_\_ LMP \_\_\_\_\_ Problems \_\_\_\_\_

If >16yrs, have you been taught a self breast exam? \_\_\_\_\_

Do you perform it monthly? \_\_\_\_\_ Have you been to see a Gynecologist? \_\_\_\_\_