



PEDIATRIC/TEEN NEW PATIENT HISTORY

DATE:

**PERSONAL PROFILE**

NAME:	NAME YOU WOULD LIKE US TO USE:
AGE:	GRADE IN SCHOOL (IF APPLICABLE):
BIRTH DATE:	

**CONTACT INFORMATION**

PARENT/LEGAL GUARDIAN NAME(S):	PARENT/LEGAL GUARDIAN PHONE NUMBER(S):
PARENT/LEGAL GUARDIAN ADDRESS:	NAME, PHONE NUMBER, EMAIL OF WHO TO CONTACT WITH RESULTS:
PATIENT'S PHONE NUMBER:	PATIENT'S EMAIL ADDRESS:

**GYNECOLOGIC HISTORY**

ARE YOU CURRENTLY PREGNANT?	CURRENT BIRTH CONTROL:
LAST MENSTRUAL PERIOD (FIRST DAY):	HISTORY OF VAGINAL INFECTION OR STD?
AGE PERIODS BEGAN:	HISTORY OF PREGNANCY? NO ____ YES ____
NUMBER OF DAYS BLEEDING:	RECEIVED GARDASIL VACCINE?
NUMBER OF DAYS BETWEEN PERIODS:	____ NO ____ YES (DATE) ____
ANY RECENT CHANGES IN PERIODS?	ARE YOU CURRENTLY SEXUALLY ACTIVE?
SEXUAL ORIENTATION:	

**MEDICATIONS (INCLUDE OVER-COUNTER)**

**MEDICATION ALLERGIES**

DRUG NAME/DOSE		DRUG NAME/DOSE			
1		3		1	
2		4		2	
				3	

**SOCIAL HISTORY**

**CIGARETTES** \_\_\_\_ NEVER \_\_\_\_ CURRENT \_\_\_\_ PAST \_\_\_\_ PACKS PER DAY \_\_\_\_ YEARS

**ALCOHOL** \_\_\_\_ NONE \_\_\_\_ #DRINKS PER DAY \_\_\_\_ #DRINKS PER WEEK

**RECREATIONAL DRUGS (DESCRIBE)** \_\_\_\_ CURRENT \_\_\_\_ PAST

**HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?** \_\_\_\_ NO \_\_\_\_ YES

**PERSONAL PAST MEDICAL HISTORY**

**HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (PAST OR CURRENT)**

	YES	NO	DETAILS (DATE/DESCRIPTION)
ABNORMAL HAIR GROWTH/HAIR LOSS			
ABNORMAL VAGINAL DISCHARGE			
ABNORMALLY PAINFUL/HEAVY PERIODS			
ARTHRITIS/JOINT PROBLEMS			
ASTHMA OR LUNG DISEASE			
BLOOD CLOTS IN LEGS OR LUNGS			
BLOOD TRANSFUSION			
BOWEL PROBLEMS			
CANCER			
DEPRESSION/ANXIETY			
DIABETES			
ENDOMETRIOSIS			
HEART ATTACK/ANGINA			
HERPES			
HIGH BLOOD PRESSURE			
INFERTILITY			
INVOLUNTARY LOSS OF STOOL			
INVOLUNTARY LOSS OF URINE			
IRREGULAR OR ABSENT PERIODS			
KIDNEY INFECTION/STONES			
LUMPS OR PAIN IN BREASTS			
LUPUS/ COLLAGEN VASCULAR DISEASE			
MENOPAUSE SYMPTOMS			
PREMATURITY? WHAT GESTATIONAL AGE?			
OTHER:			

CONDITIONS CONTINUED:	YES	NO	DETAILS (DATE/DESCRIPTION)
MIGRAINES/HEADACHES			
REFLUX/STOMACH ULCER			
SEIZURES			
SEXUALLY TRANSMITTED DISEASES			
STROKE			
SUBSTANCE ABUSE			
THYROID DISEASE			
UNEXPLAINED WEIGHT LOSS OR GAIN			
UTERINE FIBROIDS			
OPERATIONS/ HOSPITALIZATIONS			
PROCEDURE/ REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1			
2			
3			
4			
5			
6			
FAMILY HISTORY			
<b>MOTHER</b>	___ LIVING	___ DECEASED- AGE/ CAUSE OF DEATH	
<b>FATHER</b>	___ LIVING	___ DECEASED- AGE/ CAUSE OF DEATH	
<b>SIBLINGS</b>	#LIVING___	#DECEASED_ AGES/ CAUSES OF DEATH	
<b>CHILDREN</b>	#LIVING___	#DECEASED_ AGES/ CAUSES OF DEATH	
ILLNESS	YES	WHICH RELATIVES/ AGE OF ONSET	
BIRTH DEFECTS			
BLOOD CLOTS IN LEGS/LUNGS			
BREAST CANCER			
COLON CANCER			
CYSTIC FIBROSIS			
DOWNS SYNDROME			
HEART DISEASE			

HIGH BLOOD PRESSURE		
<b>FAMILY HISTORY CONTINUED</b>	<b>YES</b>	<b>WHICH RELATIVES/ AGE OF ONSET</b>
HIGH CHOLESTEROL		
OVARIAN CANCER		
SICKLE CELL DISEASE		
STROKE		
TAY SACHS DISEASE		
UTERINE CANCER		
OTHER FAMILY HISTORY		

**REVIEW OF SYSTEMS**

**ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING BODY SYSTEMS?  
(CIRCLE THOSE THAT APPLY)**

GENERAL	fatigue	fever	weight gain	weight loss	
HEAD/EARS/NOSE/THROAT	headaches	sore throat	decreased hearing		
BREAST	breat lumps	breast tenderness	nipple discharge		
CARDIOVASCULAR	chest pain	irregular heartbeat			
RESPIRATORY	shortness of breath	cough	wheezing		
GASTROINTESTINAL	nausea	vomiting	diarrhea	constipation	abdominal pain
SKIN	rashes	skin lesions			
NEUROLOGIC	seizures	tingling	numbness		
MUSCULOSKELETAL	joint pain	joint swelling			
ENDOCRINE	hair loss	temperature intolerance	abnormal hair growth		

PRIMARY CARE PHYSICIAN:

PRIMARY CARE PHYSICIAN PHONE NUMBER, ADDRESS, NAME OF PRACTICE:

DID YOUR PRIMARY CARE PHSYICIAN SEND YOU TO CWCC?

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE:

ARE YOU HERE TODAY FOR A \_\_\_\_\_ ROUTINE ANNUAL EXAM OR A PROBLEM? \_\_\_\_\_

IF YOUR VISIT IS FOR A PROBLEM, PLEASE DESCRIBE:

THANK YOU!