



**MEDICAL HISTORY**

NONE

Please check any physical or mental health conditions (or problems) you have now or have ever had. Add the year it started, if known. Please add any other conditions if not listed.

✓	DATE	CONDITION	✓	DATE	CONDITION	✓	DATE	CONDITION
		ADDADHD			Heart Disease			Scoliosis
		Allergies			Heart murmur			Serious Infections: - Pneumonia (in the hospital) - Strep throat - Urinary Tract
		Asthma			Heartburn/GERD			
		Cancer			Hepatitis C			
		Depression			HIV/AIDS			
		Developmental Delay			Hypertension (High Blood Pressure)			Sickle Cell
		Diabetes			Inflammatory bowel disease			Sleep Apnea
		Dialysis			Jaundice			Stroke
		Eczema			Lead poisoning			Vision changes
		Epilepsy/seizures			Neuromuscular Dx			
		Growth failure			Obesity			
		Headaches			Otitis Media			
		Hearing Loss			Pain all the time (Chronic)			

Have you had any serious injuries, trauma or accidents or hospital stay? Please list with the date, if known.

DATE	DESCRIPTION

How many times have you been seen in an Emergency Department in the past year?  None  1-3  4-6  7 or more

Do you have any concerns with growth and development, school, friends, family, etc?  No  Yes - Please describe:

**SURGICAL HISTORY (AND PROCEDURES)**

NONE

Do you have any metal or plastic implants?  Yes – valves rods pins shunt fistula

pacemaker or other heart device cardiac stent

Have you had an organ or tissue transplant?  Yes – What organ/tissue? \_\_\_\_\_

Have you ever had – abnormal EKG abnormal Chest X-Ray problems with anesthesia blood transfusion

Please list any surgeries or procedures you have had. Add the date if you know it.

✓	DATE	CONDITION	✓	DATE	CONDITION	✓	DATE	CONDITION
		Adenoidectomy			Gastrostomy			Orthopedic -
		Appendectomy			Heart -			Tonsillectomy
		Cleft lip			Hernia - <input type="checkbox"/> Inguinal <input type="checkbox"/> Umbilical			Traumatic injury
		Cleft palate						VP Shunt
		Ear tubes			Lymph node biopsy			

**FAMILY HISTORY**

NONE

Mother's height \_\_\_\_\_ Father's height \_\_\_\_\_

Please list those in your family who have or have had the following:

Relationship	Name	Status Alive		Cancer	Depression	Diabetes	Heart attack (note age)	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Cystic fibrosos	Death from infection or unexpected before 30 years old	Diabetes before 30 years old	Heart attack before 40 years old	Problems with anesthesia	Details	
		Yes	No															
Mother																		
Father																		
Sister																		
Brother																		

**PREVENTIVE CARE**

Are your vaccinations up to date?  Yes  No

**SOCIAL/PERSONAL HISTORY**

Do you live with  Father  Mother  Grandparent(s)  Guardian  Foster care  At a facility

Other: \_\_\_\_\_

Are you in school?  No  Yes – Grade \_\_\_\_\_  Home schooled  Homebound  Special Education

Other: \_\_\_\_\_

Are you in a special program?  Gifted/accelerated  IEP  Other: \_\_\_\_\_

How many days of school have you missed this academic year because of illness?  None  1-5  6-10  >10

Are you sexually active?  Yes  No  Not Currently – Partners  Female  Male

Birth Control/Protection used:  None  Abstinence  Pull Out  Condom  Injection

Insert/implant Type: \_\_\_\_\_  Pills  Patch  Rhythm  Spermicide  Surgical Other: \_\_\_\_\_

If female: Date of last menstrual period \_\_\_\_\_ Pregnant  Yes  No Breastfeeding  Yes  No

Do you use tobacco?  Yes  Never  Quit – Quit Date \_\_\_\_\_  Chew/Snuff

Passive (Live with a smoker) – Name \_\_\_\_\_

If yes – how many packs per day?  less than 1  1  greater than 1  Other: \_\_\_\_\_

For how many years?  less than 1  1-5  6-10  more than 10

Do you drink alcohol?  No  Quit (date) \_\_\_\_\_

Yes - Drinks per week: \_\_\_\_\_ Glasses of wine \_\_\_\_\_ Cans of Beer \_\_\_\_\_ “Shots” or mixed drinks

Do you use drugs?  No

Yes – Times per week: \_\_\_\_\_ Types:  Marijuana  Methamphetamines  Cocaine  IV

Other: \_\_\_\_\_

Would you like information about quitting?  Yes  No

Are you on special diet: No Yes - Describe: \_\_\_\_\_

Do you have any problems sleeping No Yes – nightmares sleep walking bedwetting snoring  
teeth grinding trouble getting to sleep trouble staying asleep Other: \_\_\_\_\_

How much time do you spend in front of the television and/or computer each day?  
None 1 hour 2-4 hours >4 hours

Do you exercise regularly? No Yes –  
How many times per week? \_\_\_\_\_

For how long? \_\_\_\_\_

What do you like to do for fun? \_\_\_\_\_

Do you use: Glasses Contacts Hearing aids False teeth Cane Walker Wheel chair

Safety: Do you use? booster seat or seat belt in the car Bike helmet

Have you traveled outside the United States within last year? Yes No If yes, where? \_\_\_\_\_

Please read each section and match the answer to the amount of activity you are able to do –

Without stopping can you:
walk up 3 flights of steps or walk several blocks? <input type="checkbox"/> Yes <input type="checkbox"/> No
walk up more than 1 flight of steps or 2 blocks? <input type="checkbox"/> Yes <input type="checkbox"/> No
walk up one flight of steps or less. <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get short of breath or have chest pain when lying in bed? <input type="checkbox"/> Yes <input type="checkbox"/> No

**NYHA CATEGORIES**

Symptoms = shortness of breath, angina  
*Class 1 – No symptoms and no limitation in ordinary physical activity.*

*Class 2 – Mild symptoms and slight limitation during ordinary activity.*

*Class 3 – Marked limitation in activity due to symptoms.*

*Class 4 – Severe limitations. Experiences symptoms even while at rest.*

Why do you need to stop walking? (Check all that apply)

- Not applicable
- Chest pain/pressure
- Joint / back pain
- Muscle cramps
- Overweight
- Short of breath
- Weak, tired, dizzy

Completed by \_\_\_\_\_ Date \_\_\_\_\_  
NAME/SIGNATURE

Interpreter present \_\_\_\_\_ Cyracom phone ID # \_\_\_\_\_  
NAME/SIGNATURE

Reviewed by \_\_\_\_\_ Entered into EMR Date \_\_\_\_\_  
NAME/SIGNATURE