LAKESHORE FAMILY MEDICINE
CHILD HEALTH INFORMATION

NAME:_____DOB_____

(DAY NUMBER PLEASE)
HOME PHONE_____CELL PHONE_____

GENDER:
◯ MALE
◯ FEMALE

LIVING STATUS:
◯ BOTH PARENTS
◯ SINGLE PARENT
◯ OTHER

EMERGENCY CONTACTS:

NAME:_____PHONE#_____

RELATIONSHIP:_____

NAME:_____PHONE#_____

RELATIONSHIP:_____

IS YOUR CHILD UNDER A COURT ORDER THAT MAY AFFECT WHO CAN ASK FOR INFORMATION OR BE PRESENT DURING VISITS?

◯ YES
◯ NO

IF THERE IS AN ORDER PLEASE BRING IT TO THE OFFICE FOR THE CHILD'S CHART.

MEDICATION LIST:

PLEASE LIST ALL MEDICATIONS, VITAMINS AND HERBAL SUPLIMENTS:

MEDICATION	**HOW MUCH**	**HOW OFTEN**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL YOUR CHILD'S CURRENT MEDICAL CONDITONS

(EXAMPLES: Diabetes, previous heart attacks, broken bones, any medical hardware that cannot be removed)

MEDICAL CONDITION	**DATE IT HAPPENED**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ADOLESCENT SECTION:

ARE YOU A SMOKER?

◯ YES
◯ NO

◯ 1-HALF PACK PER DAY ◯ PACK A DAY ◯ 2 PACKS A DAY ◯ MORE THAN 2 PACKS A DAY

◯ I USED TO SMOKE BUT QUIT DATE:_____

IF YOU USED TO SMOKE PLEASE INDICATE HOW MUCH YOU SMOKED EACH DAY.

DO YOU CHEW TOBACCO?

◯ YES
◯ NO

ALCOHOL CONSUMPTION/RECREATIONAL SUBSTANCES

PLEASE BE AWARE THAT ALL INFORMATION IS COLLECTED FOR MEDICAL USE ONLY AND WILL NOT BE VIEWED BY ANYONE OTHER THAN THE PROVIDER FOR MEDICAL TREATMENT ONLY.

DO YOU USE ANY RECREATIONAL SUBSTANCES?

SUBSTANCE	HOW MUCH
_____	_____
_____	_____
_____	_____

DO YOU FEEL THAT THIS SUBSTANCE IS INTERFERING WITH THE WAY YOU LIVE OR CAUSING PROBLEMS AT SCHOOL OR HOME?

◯ YES

◯ NO

DO YOU FEEL YOU NEED HELP GETTING TREATMENT FOR SUBSTANCE ABUSE?

◯ YES

◯ NO

DO YOU LIVE WITH SOMEONE YOU FEEL NEEDS HELP WITH SUBSTANCE ABUSE?

◯ YES

◯ NO

DO YOU DRINK CAFFINATED DRINKS?

◯ COFFEE HOW MANY CANS/BOTTLES_____

◯ TEA HOW MANY CANS/BOTTLES_____

◯ COLA/POP HOW MANY CANS/BOTTLES_____

IF YOU HAVE A FAMILY HISTORY OF CERTAIN ILLNESSES, THESE ILLNESSES CAN SOMETIMES APPEAR IN DECENDENTS. PLEASE ANSWER THE FOLLOWING.

FAMILY HISTORY SECTION:

ARE THE CHILDS PARENTS STILL LIVING? IF THE ANSWER IS NO, HOW OLD WAS THE PARENT WHEN THEY PASSED? DO YOU KNOW WHAT CAUSED THEIR PASSING?

MOTHER:_____

_____

FATHER:_____

_____

DID THE CHILD HAVE ANY GRANDPARENTS, BROTHERS OR SISTERS WHO PASSED AWAY WHEN THEY WERE YOUNG?

WHO PASSED AWAY?_____

WHAT DID HE/SHE PASS AWAY FROM?_____

_____

HOW OLD WAS THIS PERSON?_____

HAVE YOU EVER HAD ANY UNCOMMON ILLNESSES SUCH AS RHEUMATIC FEVER, AMPUTATIONS, APPENDICITIS OR TONSILLECTOMY?

ILLNESS_____DATE:_____

ILLNESS_____DATE:_____

ILLNESS_____DATE:_____

ILLNESS_____DATE:_____

DO YOU HAVE ANYTHING ELSE ABOUT CHILD YOU WOULD LIKE YOUR PROVIDER TO KEEP IN YOUR CHILD'S CHART?

_____

_____

_____

_____

DOES YOUR CHILD SEE ANY SPECIALISTS?

WE WILL NEED TO KNOW WHO YOUR OTHER DOCTOS ARE, WHAT THEY TREAT YOU FOR AND WHAT MEDICATONS THEY FILL FOR YOU.

PROVIDER	DIAGNOSIS	MEDICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

HAS THE CHILD HAD ANY SURGERY OR EMERGENCY ROOM VISITS?

MEDICAL CONDITION	**DATE IT HAPPENED**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____