

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 SUPPLIMENTS:

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
