Community Health Center of the Black Hills, Inc.

Rapid City, SD 57701
(605) 721-8939 FAX (605) 394-5217

Pediatric/Adolescent Health History (Ages 0-17)

Patient #: _____ Today's Date :_____

PATIENT NAME:	**DATE OF BIRTH:**
PARENT/LEGAL GUARDIAN'S NAME: **Circle: Mother / Father / Guardian / Other**	

Birth History: *Please fill out if child less than 5 years of age*

No Birth History Available:	☐ Patient Adopted	☐ Foster Care
Type of delivery:	☐ Vaginal delivery	☐ C-section
Was child premature? *If Yes, how early?*_____ How much did child weigh at birth? _____ pounds _____ounces	☐ Yes	☐ No
Was child a:	☐ single birth	☐ multiple birth (twin, triplet, etc.)
Was there any complications associated with the pregnancy or delivery? *If yes, please explain:*	☐ Yes	☐ No
Does child have any birth defects? *If yes, please explain:*	☐ Yes	☐ No
Was child exposed to Group B strep during pregnancy &/or delivery? *If yes, was mom treated prior to delivery?*	☐ Yes ☐ Yes	☐ No ☐ No
Was the child in intensive care after birth? *If yes, please explain:*	☐ Yes	☐ No
Did mom have diabetes associated with pregnancy?	☐ Yes	☐ No
Did mom smoke during pregnancy?	☐ Yes	☐ No
Did mom drink alcohol during pregnancy?	☐ Yes	☐ No
Did mom use any drugs during pregnancy? *If yes, please list what drug:*	☐ Yes	☐ No
Was mom HIV or Hepatitis C positive? *If yes, which one:*	☐ Yes	☐ No
Any history of other STDs in mom? *If yes please list:*	☐ Yes	☐ No

Immunization History

Are Child's Immunizations Current?	☐ Yes	☐ No
Is Immunization record available?	☐ Yes	☐ No
Have you reviewed and signed clinic policy regarding vaccines if choosing not to vaccinate?	☐ Yes	☐ No

Childs Health History: *Please check conditions child has or has had.*

☐ Check if no Past Medical History:

☐ Skin problems ☐ Eczema ☐ _____	☐ Eye disorders ☐ Vision problems ☐ Glasses/contacts	☐ Ear infections ☐ Hearing difficulty	☐ Asthma ☐ RSV ☐ Pneumonia ☐ Cystic Fibrosis
☐ Allergic Rhinitis ☐ Food allergies ☐ Other allergies	☐ Cardiac problems ☐ Murmur ☐ Congenital heart ☐ High cholesterol	☐ GERD ☐ Constipation ☐ Pyloric Stenosis	☐ Kidney problems ☐ Polycystic kidney ☐ Proteinuria ☐ Nephrotic syndrome
☐ UTIs ☐ VU reflux ☐ Enuresis (bed wetting)	☐ STDs ☐ Gonorrhea ☐ Chlamydia ☐ _____	☐ Rheumatological ☐ Arthritis ☐ Lupus	☐ Endocrine ☐ Diabetes Type I or II ☐ Thyroid d/o
☐ Orthopedic problem ☐ _____	☐ Blood Disorders ☐ Anemia ☐ Bleeding d/o	☐ Cancer ☐ _____ ☐ _____	☐ Immunologic Disorders ☐ _____ ☐ _____
☐ Neurological ☐ Headaches ☐ Febrile seizure ☐ Epilepsy ☐ Cerebral palsy	☐ Developmental delay ☐ Special education ☐ Autism ☐ Genetic Disorder ☐ Down Syndrome	☐ Concussion ☐ Sports Injury ☐ _____	☐ Other medical problems not listed ☐ _____ ☐ _____
☐ ADHD ☐ Depression ☐ Anxiety ☐ _____ ☐ _____	☐ Alcoholism ☐ Substance use disorder	☐ Abuse/Neglect ☐ Psychological ☐ Sexual ☐ Physical ☐ Reported	Any specialty providers your child sees? Please list: _____ _____

Has child had any prior surgeries? ☐ Yes ☐ No

If yes, please indicate which surgeries child has had.

☐ Tonsils and Adenoids	☐ Tubes in Ears
☐ Thyroid Surgery	☐ Heart Surgery (Cardiothoracic surgery) Explain:
☐ Lung Surgery Explain:	☐ Abdominal Surgery Explain:
☐ Appendix	☐ Gallbladder (Cholecystectomy
☐ Dental surgery	☐ Hernia
☐ Pyloric Stenosis	☐ Joint or bone surgery (Orthopedic Surgery) Explain:
☐ Bladder Surgery	☐ Kidney Surgery
☐ Other:	

The child is currently living with:
☐ Lives with parents
☐ Relatives other than parents: Explain:
☐ Stepfamily: Step mom / Step dad
☐ Grandparents
☐ Foster Home
☐ Juvenile Group Home (ward of State or County)
☐ Other - Explain

Living Situation:		
☐ Homeless Shelter	☐ On the Street	
☐ Doubling Up	☐ Permanent Supportive Housing	
☐ Transitional Housing	☐ Other	
What is child's Ethnicity?		
☐ Hispanic/Latino	☐ Non-Hispanic / Latino	
What is child's Race?		
☐ Asian	☐ Native Hawaiian	☐ Other Pacific Islander
☐ African American	☐ American Indian / Alaskan Native	☐ White
☐ More than one race	☐ Do not wish to say	
What is child's Gender?		
☐ Female	☐ Female-to-Male/ Transgender Male	
☐ Male	☐ Male-to-Female/ Transgender Female	
☐ Other	☐ Choose not to disclose	
What is child's Sexual Orientation?		
☐ Heterosexual	☐ Something else	
☐ Homosexual	☐ Don't know	
☐ Bisexual		

Does child have a history of:		
Alcohol use	☐ Yes	☐ No
Cigarette use	☐ Yes	☐ No
Marijuana use	☐ Yes	☐ No
Drug use	☐ Yes	☐ No
Abuse	☐ Yes	☐ No
If yes, please circle - physical abuse / psychological abuse / sexual abuse		
Was abuse reported?	☐ Yes	☐ No

Is child sexually active? ☐ Yes ☐ No *Current form of birth control:*

In the last year, were you ever worried that your food would run out before you could purchase more? ☐ Yes ☐ No

What grade and school does your child attend?

Family History: *Please indicate who in child's immediate family had this: (mom, dad, brother, sister, maternal grandmother, paternal grandmother, maternal grandfather, paternal grandfather)*

☐ Mother deceased ☐ Father deceased	☐ Eczema (Atopic disorders) Eczema) ☐ Psoriasis	☐ Blindness ☐ Hearing loss	☐ Allergies	☐ Asthma	☐ Cystic Fibrosis
☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Disease	☐ Congenital Heart Defect	☐ Stroke	☐ Gallstones
☐ IBS ☐ Chrons ☐ GERD	☐ Renal/Kidney Disease	☐ Gynecology	☐ Rheumatology ☐ RA ☐ Lupus	☐ Endocrine ☐ Diabetes I ☐ Diabetes II ☐ Thyroid	☐ Orthopedic
☐ Hematology ☐ Anemia ☐ Bleeding Disorder	☐ Cancer-type ☐ Leukemia	☐ Immunology	☐ Neurology ☐ Headaches ☐ Epilepsy ☐ Developmental Delay	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ ADHD	☐ Alcoholism ☐ Substance Abuse
☐ Other:					