**Care Provider to Complete**

1. **Child’s medical history**
2. **Well Child/General Pediatric history**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **History obtained/provided by:** | |  | | |
| **Primary care provider:** | |  | | |
| **Immunizations up-to-date** | **Yes  No  Unknown** | | **Pregnancy/birth issues** | **Yes  No  Unknown** |
| **Chronic/active disease** | **Yes  No  Unknown** | | **Allergies** | **Yes  No  Unknown** |
| **Hospitalizations** | **Yes  No  Unknown** | | **Surgeries** | **Yes  No  Unknown** |
| **Trauma/injury** | **Yes  No  Unknown** | |  | |
| **Specify:** | | | | |

1. **Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **History obtained/provided by:** |  | | |
| **Name of medication** | **Dosage** | **Purpose** | **Prescribing clinician** |
|  |  |  |  |
|  |  |  |  |

1. **Genitourinary history**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **History obtained/provided by:** | | | | | |
| **Genital pain/lesions/bleeding/discharge** | | | | **Yes  No  Unknown** | |
| **Rectal pain/lesions/bleeding/discharge** | | | | **Yes  No  Unknown** | |
| **Prior urinary tract infection** | | | | **Yes  No  Unknown** | |
| **Prior sexually acquired infection** | | | | **Yes  No  Unknown** | |
| **First Period** | **Yes  No** | **Age** |  | **LMP** |  |
| **Describe any significant genitourinary and/or reproductive health history:** | | | | | |

1. **Developmental and/or educational history**

|  |  |
| --- | --- |
| **History obtained/provided by:** | |
| **Developmental concerns** | **Yes  No  Unknown** |
| **Educational concerns** | **Yes  No  Unknown** |
| **Describe any significant developmental and/or educational history:** | |

1. **Behavioral and mental health history**

|  |  |
| --- | --- |
| **History obtained/provided by:** | |
| **Currently receiving mental health treatment?** | **Yes  No  Unknown** |
| **Reason for mental health services:** |  |
| **Clinician and/or practice** |  |
| **Sleep disturbance** | **Yes  No  Unknown** |
| **Poor concentration** | **Yes  No  Unknown** |
| **Anxiety** | **Yes  No  Unknown** |
| **Hypervigilance/exaggerated startle** | **Yes  No  Unknown** |
| **Re-experiencing/nightmares/flashbacks** | **Yes  No  Unknown** |
| **Avoidance/withdrawal** | **Yes  No  Unknown** |
| **Eating disorder** | **Yes  No  Unknown** |
| **Enuresis/encopresis** | **Yes  No  Unknown** |
| **Self-injurious behavior** | **Yes  No  Unknown** |
| **Hyperactivity/impulsivity** | **Yes  No  Unknown** |
| **Anger outbursts/irritability** | **Yes  No  Unknown** |
| **Depressed mood** | **Yes  No  Unknown** |
| **Suicidal behavior** | **Yes  No  Unknown** |
| **Sexualized behavior problems** | **Yes  No  Unknown** |

|  |
| --- |
| **History obtained/provided by:** |
| **Describe any significant behavioral history:** |

1. **Family medical history** *Document the health history of parents’ and immediate family*

|  |  |
| --- | --- |
| **History obtained/provided by:** |  |
| **Significant family history** | **Yes  No  Unknown** |
| **Describe significant family history:** | |

1. **Psychosocial history**

|  |  |
| --- | --- |
| **History obtained/provided by:** | |
| **Prior CPS involvement** | **Yes  No  Unknown** |
| **Prior LE/criminal history** | **Yes  No  Unknown** |
| **Domestic violence** | **Yes  No  Unknown** |
| **Trauma exposure** | **Yes  No  Unknown** |
| **Substance misuse/disorder** | **Yes  No  Unknown** |
| **Mental health concerns/diagnosis:** | **Yes  No  Unknown** |
| **Describe any significant psychosocial history:** | |

1. **Review of systems**

**Are there any significant concerns?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **History obtained/provided by:** | |  | | |
| **General** | **Yes  No  Unknown** | | **GI** | **Yes  No  Unknown** |
| **Dental** | **Yes  No  Unknown** | | **Respiratory** | **Yes  No  Unknown** |
| **Hearing** | **Yes  No  Unknown** | | **Musc/Skel** | **Yes  No  Unknown** |
| **Visions** | **Yes  No  Unknown** | | **GU** | **Yes  No  Unknown** |
| **ENT** | **Yes  No  Unknown** | | **Endo** | **Yes  No  Unknown** |
| **Ophthalmology** | **Yes  No  Unknown** | | **Heme/Lymph** | **Yes  No  Unknown** |
| **Skin** | **Yes  No  Unknown** | | **Neuro** | **Yes  No  Unknown** |
| **CV** | **Yes  No  Unknown** | | **Psych** | **Yes  No  Unknown** |
| **Describe significant findings:** | | | | |