PLEASE PRINT THESE FORMS AND BRING THEM FILLED OUT TO YOUR APPOINTMENT

WHOLE CHILD Pediatrics

Name_____ Date_____

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns ad conditions. If you are a current patient there is a shorter update form you can use. If you cannot remember specific details. please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Mere were you getting you- care before?_____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in dicing things? ☐ No ☐ Yes
Feeling down, depressed or hopeless? ☐ No ☐ Yes

REVIEW OF SYNPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none *of* the symptoms apply to you. List other concerns above.

General
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/ weakness
- ☐ Fall asleep during day when sitting
- ☐ Fever, chills
- ☐ No problems

Skin
- ☐ New or change in mole
- ☐ Rash/itching
- ☐ No problems

Breast
- ☐ Breast lump/pain nipple/discharge
- ☐ No problems

Ears/Nose/Throat
- ☐ Nosebleeds. trouble swallowing
- ☐ Frequent sore throat, hoarseness
- ☐ Hearing loss / ringing in ears
- ☐ No problems

Eyes
- ☐ Change in vision/eye pain/redness
- ☐ No problems

Cardiovascular
- ☐ Chest pan / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ No problems

Respiratory
- ☐ Cough / wheeze
- ☐ Loud snoring altered breathing during sleep
- ☐ Short of breath with exertion
- ☐ No problems

Gastrointestinal
- ☐ Heartburn/reflux/indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ No problems

Genitourinary
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nighttime urination or increased frequency
- ☐ Discharge: penis or vagina
- ☐ Concern with sexual function
- ☐ No problems

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle/joint pain
- ☐ No problems

Endocrine
- ☐ Heat or cold sensitivity
- ☐ No problems

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ No problems

Neurological
- ☐ Headache
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness/ tingling
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ No problems

Allergic/Immune
- ☐ Hay fever / allergies
- ☐ Frequent infections
- ☐ No problems

Psychiatric
- ☐ Anxiety / stress / irritability
- ☐ Sleep problem
- ☐ Lack of concentration
- ☐ No problems

Women only
- ☐ Pre-menstrual symptoms (bloating cramps, irritability)
- ☐ Problem with menstrual periods
- ☐ Hot flashes / night sweats
- ☐ No problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don t know the information ☐

Tetanus (Td) _____ With Pertussis (Tdap) ___ Varicella (Chicken Pox) shot *or* illness ____ Pneumovax (pneumonia) ___

Influenza (flu shot) __ Hepatitis A ____ Hepatitis B____MMR _____ Meningitis Zostavax (shingles)_____HPV __