Patient History Form - 6 year and Up

Patient Name_____ DOB_____

Sex M F History given by_____ Date_____

Patient Information:

Are immunizations up to date? Yes or No

Acute Illness / Chronic Illness / Medical Issues / Mental Health Issues:
List all past and present diagnoses

_____

_____

_____

Hospitalizations or ER Visits: List any that have occurred since the last well check

_____

_____

_____

Surgeries: List any that have occurred since the last well check

_____

_____

Allergies: _____

Medications: name, dose, what is it given for?

_____

_____

_____

Social History:

Who does the patient live with?

_____

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

_____

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: _____

Does anyone in the household smoke or vape? _____

Any recent travel since the last well check? Yes No Where? _____

Family History - Please provide information for patient's parents, siblings and grandparents:

Heart Problems/ Heart Attack	Y	N	Migraines/Headaches	Y	N	Allergies	Y	N
High Cholesterol	Y	N	ADHD/ADD	Y	N	Eczema	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Depression or Anxiety	Y	N
Asthma	Y	N	Thyroid Problems	Y	N	Obesity	Y	N
Stomach Problems	Y	N	Bleeding or Clotting Problems	Y	N	Alcoholism	Y	N
Kidney/Bladder Problems	Y	N	Anemia	Y	N	Drug Abuse	Y	N
Seizures	Y	N	Arthritis	Y	N	Cancer	Y	N

Reporte de Historia Medica - De Seis Años y Mayor

Nombre De Paciente_____ **Fecha De Nacimiento** _____

Sexo _____ **Historia Dada Por** _____ **Fecha** _____

Informacion Del Paciente:

Las vacunas estan todas corrientes? Si No

Enfermedad Grave / Enfermedad Crónica / Problemas Médicos o Mental: pasado o presente

_____

_____

Hospitalizaciones o visitas a la sala de emergencias: desde el último examen anual

_____

_____

Cualquier cirugía desde el último examen anual:

_____

Alergias: _____

Medicamentos: Nombre, dosis, y la indicaccion

_____

_____

Historia Social:

¿Con quién vive el paciente?

_____

Si los padres biológicos están separados o no viven en el mismo hogar que el paciente, ¿con qué frecuencia visita el niño el otro hogar?

_____

¿Hay mascotas dentro o fuera del hogar? Si No

si es así, liste mascotas: _____

¿Alguien en tu casa fuma o vape? _____

Recientemente viajado: Si No ¿dónde?_____

Historia Familiar - Por favor, proporcione información para los padres, hermanos y abuelos del paciente

Problemas del corazón	Si	No	Migrañas o dolores de cabeza	Si	No	Alergias	Si	No
Colesterol alto	Si	No	Problemas de atención	Si	No	Eczema	Si	No
Alta presion sanguinea	Si	No	Diabetes	Si	No	Depresión o ansiedad	Si	No
Asma	Si	No	Problemas tiroideos	Si	No	Obesidad	Si	No
Problemas estomacales	Si	No	Problemas de hemorragia o coagulación	Si	No	Alcoholismo	Si	No
Problemas de riñón o vejiga	Si	No	Anemia	Si	No	Abuso de drogas	Si	No
Convulsiones	Si	No	Artritis	Si	No	Cáncer	Si	No

Questions About Your Child and Tuberculosis (TB)

Child's Name _____ Date of Birth _____

Your Name _____

Today's Date _____

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a TB skin test. The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date _____			
2. Have you ever been told that your child had a positive TB skin test (TST)? If yes, when? Please tell us the date _____			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.			
Has your child been around anyone with any of these problems?			
Has your child been around anyone sick with TB?			
Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit? _____			
6. Do you know if your child has spent more than 3 weeks with anyone who:			
Uses needles for drug use?			
Has AIDS?			
Was or is in jail or prison?			
Has just come to the United States from another country?			

FOR THE PROVIDER:

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

PPD administered Yes___ No___
If yes,
Date administered ____/____/____ Date read ____/____/____ PPD response_____ mm

PPD provider _____ _____
Signature Printed Name
If chest x-ray done, date and results
_____

Provider phone number_____City_____County_____

If positive, referral to local/regional health department/specialist? Yes___ No___
If yes, name of health dept/specialist _____

Contact your local or regional health department if assistance is needed.