Primary Health Solutions – Comprehensive Health Assessment – PEDS (0-18 Years Old)

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth: MM/DD/YYYY	Date Completed: MM/DD/YYYY

Current Medications: (Name and Dose) *Include prescription, over the counter medications, vitamins and herbal preparations*	**Allergies:** *Please list all allergies including medication, environmental, food and insect*

Hospitalizations, Surgeries, Serious Injuries: Year:	**Last Exam:** *Please list well child checks, dental, vision, school physicals, etc.* **Provider: Date:**

Check conditions below that the patient has now or has had in the past:

- ☐ Abdominal Pain
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Birth Defects
- ☐ Chickenpox
- ☐ Concussion/Head Injury
- ☐ Congenital Heart Disease
- ☐ Constipation
- ☐ Developmental Delay
- ☐ Diabetes, Type: 1 2
  Last HgA1c: _____
- ☐ Dizziness, light-headed or passing out
- ☐ Eczema/Hives/Skin Rash
- ☐ Epilepsy/Seizures
- ☐ Genetic Disorder
- ☐ Genital Discharge/Pain
- ☐ GERD/Acid Reflux
- ☐ Heart Murmur
- ☐ Hepatitis
  Type: A B C
- ☐ Kidney Problems
- ☐ Lead concerns
- ☐ Mental Health Problems
  Describe: _____
- ☐ Migraines/Chronic Headaches
- ☐ Scoliosis
- ☐ Sexually Transmitted Infection
- ☐ Sinus Trouble
- ☐ Stomach Problems
- ☐ Thyroid Problems
- ☐ Urinary Problems/Pain
- ☐ Other:
  _____

Family History: *Check if any family members have had any of the following and their relationship to the patient*

☐ Alcoholism/Drug Addiction	Relationship: _____	☐ High Blood Pressure	Relationship: _____
☐ Cancer, Type: _____	Relationship: _____	☐ Lung Disease	Relationship: _____
☐ Depression	Relationship: _____	☐ Stroke	Relationship: _____
☐ Glaucoma	Relationship: _____	☐ Diabetes	Relationship: _____
☐ Heart Disease/Heart Attack	Relationship: _____	☐ Other: _____	Relationship: _____
☐ Mental Health Problems	Relationship: _____	☐ Other: _____	Relationship: _____

Nutrition: *Please check all that apply for the patient*

Special diet?	☐ Yes ☐ No If yes, describe: _____
Significant weight change in the past 6 months?	☐ Gain ☐ Loss Pounds: _____
Problems with chewing or swallowing?	☐ Yes ☐ No If yes, describe: _____
Do you feel the patient eats as it should?	☐ Yes ☐ No If yes, describe: _____

Education:

Current Grade in School: _____	☐ N/A ☐ Preschool ☐ Daycare
Has the patient repeated any grade levels?	☐ Yes ☐ No
Has the patient had difficulties in school or identified for special education?	☐ Yes ☐ No Describe: _____

Misc:

Is the patient hearing impaired?	☐ Yes ☐ No
Is the patient visually impaired?	☐ Yes ☐ No
Does the household have trouble with any of the following?	☐ Food ☐ Utilities ☐ Housing ☐ Transportation ☐ Clothing
Cultural/Religious Needs and Preferences:	_____ _____
Does anyone in the household or someone the patient spends a lot of time with smoke?	☐ Yes ☐ No
When was the patient's last vaccinations given?	_____
Where were the patient's last vaccinations given?	☐ Ohio ☐ N/A ☐ Other State: _____ ☐ Other Country: _____
Was there anything significant during the course of pregnancy or delivery?	☐ Yes, Describe: _____ ☐ No ☐ Unknown ☐ Oxygen given at birth How long? _____

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Dental: *Please check all that apply, please describe*

Prosthetic heart valve	☐ _____
Artificial joint	☐ _____
HIV/AIDS	☐ _____
Pacemaker	☐ _____
Herpes/cold sores	☐ _____
Sickle cell	☐ _____
Oral sores/bleeding gums	☐ _____
When was the patient's last dental x-rays?	_____
Does the patient brush?	☐ Yes ☐ No
How many times per day?	_____
Does the patient floss?	☐ Yes ☐ No
Has the patient had a "bad" dental experience?	☐ Yes ☐ No Describe: _____
Is the patient currently experiencing dental pain or discomfort?	☐ Yes ☐ No
Does the patient have clicking, popping or discomfort in the jaw?	☐ Yes ☐ No
Has the patient ever had a serious injury to your head or mouth?	☐ Yes ☐ No
Does the patient wear dentures or partials?	☐ Yes ☐ No

Vision: *Please check all that apply*

Itching	☐ Describe: _____
Tearing/burning	☐ Describe: _____
Double vision	☐ Describe: _____
Blurry vision	☐ Describe: _____
Floaters	☐ Describe: _____
Flashes	☐ Describe: _____
History of eye trauma or eye surgery	☐ Describe: _____
History of cataracts	☐ Describe: _____
History of glaucoma	☐ Describe: _____
Eye redness	☐ Describe: _____
Difficulties reading or learning to read	☐ Describe: _____
Lose place when reading	☐ Describe: _____

Female Health:

☐ N/A – If the patient is male OR if patient is not menstruating

Birth control: ☐ None ☐ Pills☐

Other: _____

Is the patient pregnant?

☐ Yes ☐ No ☐ Unsure

If yes, due date: _____

Age of first menstrual period: _____

Last menstrual period: _____

# of pregnancies: _____

# of living children: _____

# of live births: _____

# of miscarriage/abortions: _____

Social Habits for 12 Years Old and Older: ☐ N/A – If the patient is under 12 years old

Does the patient smoke?	☐ Yes ☐ No	Does the patient use marijuana?	☐ Yes ☐ No
Does the patient use smokeless tobacco	☐ Yes ☐ No	Does the patient use illegal drugs?	☐ Yes ☐ No
Does the patient vape?	☐ Yes ☐ No	Does the patient use alcohol?	☐ Yes ☐ No
How many times does the patient use products containing caffeine?	_____	Has the patient had more than 2 emergency room/hospital visits in the last 30 days?	☐ Yes ☐ No
Does the patient feel isolated?	☐ Yes ☐ No	Does the patient feel physically and emotionally safe where they live?	☐ Yes ☐ No
Is the patient sexually active?	☐ Yes ☐ No	How often does the patient see or talk to people you care about or feel close to?	_____
Does the patient have unprotected sex?	☐ Yes ☐ No	In the past year, has the patient been afraid of their partner or ex-partner?	☐ Yes ☐ No

Is the patient under the care of another provider? ☐Yes ☐ No If yes, provider name: _____

Is the patient under the care of a dentist? ☐Yes ☐ No If yes, provider name: _____

FOR STAFF USE ONLY

Provider Name and Credentials: _____ Date: _____

Provider Signature: _____

Provider Name and Credentials: _____ Date: _____

Provider Signature: _____