

PEDIATRIC & ADOLESCENT SELF ASSESSMENT FORM

PRINT this form, fill it out, then fax it to us or bring it to your visit. Find the picture of a printer in the upper left corner of this form and click on it to print. Thanks!

Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ years, _____ months. Sex: male female Race: _____

Child lives with: _____ Relationship: _____

Mother's name: _____ Occupation: _____

Father's name: _____ Occupation: _____

PAST MEDICAL HISTORY

1. Birth history:

A. Pregnancy/delivery problems? _____

B. Birth weight: _____ Length: _____

C. Newborn problems? _____

2. Social: _____ grade in school Academic issues: _____

3. Development:

Roll over _____ Sit alone _____ Stand alone _____

Walk _____ Say words _____ Toilet training _____

4. Allergies: none Medication: _____ Other: _____

5. Serious injuries / other illnesses: _____

6. Hospitalizations /Illnesses:	Date:	Physician:	Reason:
<input type="checkbox"/> surgery <input type="checkbox"/> illness	_____	_____	_____
<input type="checkbox"/> surgery <input type="checkbox"/> illness	_____	_____	_____
<input type="checkbox"/> surgery <input type="checkbox"/> illness	_____	_____	_____

7. Severe head trauma: YES NO if YES, explain: _____

8. Current / recent medications:	Medication	Dose	Frequency
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

FAMILY HISTORY

9. Family Statistics:	Age	Height	Weight	Age of Puberty/Menses	Health
• Father:	_____	_____	_____	_____	_____
• Mother:	_____	_____	_____	_____	_____
• Sibling: male female	_____	_____	_____	_____	_____
• Sibling: male female	_____	_____	_____	_____	_____
• Sibling: male female	_____	_____	_____	_____	_____

10. Family history of: (please check YES if any of the following applies to a family member and list that relative)
Family Member: _____

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Birth defects / handicap	_____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Delayed adolescence	_____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Early puberty	_____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Severe short stature	_____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Infertility or irregular menses	_____

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|------------------------------|-----------------------------|--------------------------------|-------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Excessive hair production | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diabetes | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Thyroid disease or goiter | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Pituitary abnormality | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Newborn death | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Mental retardation | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Seizure disorder | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cancer | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart attack/stroke(before 50) | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | High cholesterol | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Kidney or liver problems | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hereditary disease | _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Other | _____ |

MEDICAL SYSTEM REVIEW

1. General Health: normal

<input type="checkbox"/> Poor health	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unexplained weight gain
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Unexplained fever	<input type="checkbox"/> Behavioral problems (explain):
<input type="checkbox"/> Other: _____		
2. Central Nervous System Problems: none

<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Delays in development		<input type="checkbox"/> Other: _____
3. Eye Problems: none

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Corrective lenses	<input type="checkbox"/> Other: _____
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4. Ear Problems: none

<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Chronic ear infections	<input type="checkbox"/> Other: _____
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5. Nose and Throat Problems: none

<input type="checkbox"/> Frequent nosebleeds, sore throats or runny nose	<input type="checkbox"/> Other: _____
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6. Respiratory Problems: none

<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Frequent chest colds, bronchitis
<input type="checkbox"/> Other: _____		
7. Heart Problems: none

<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Blue spells	<input type="checkbox"/> Other: _____
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8. Stomach and Intestinal Problems: none

<input type="checkbox"/> Chronic abdominal pain	<input type="checkbox"/> Chronic diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Black/bloody stool
<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Other: _____	
9. Genital and Urinary Problems: none

<input type="checkbox"/> Urinary infection	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Frequency / Burning sensation
<input type="checkbox"/> Early puberty	<input type="checkbox"/> Delayed puberty	<input type="checkbox"/> Regular menses
<input type="checkbox"/> Irregular periods		
<input type="checkbox"/> Other: _____		
10. Bone, Joint and Muscle Problems: none

<input type="checkbox"/> Joint pain /swelling	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Curvature of the spine
<input type="checkbox"/> Other: _____		
11. Skin Problems: none

<input type="checkbox"/> Birthmarks	<input type="checkbox"/> Increased body hair	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Darkened skin at the neckline / under the arms / in body creases		
12. Blood Related Problems: none

<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Bleeding problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____	

Thanks for printing out & filling out this form. Please fax it to us at 901-763-3694 or bring it to your visit. Don't forget to print out & fill in the other general initial visit forms.