

P# _____

**CENTRAL OHIO PRIMARY CARE
FAMILY PRACTICE CENTER OF WESTERVILLE**

190-A South State Street • Westerville, Ohio 43081-2200 • www.fpcw.net • (614) 882-2349 • Fax 614-882-9005
CAROL C. HOSTETTER, D.O. • ANN H. CALLAND, D.O. • ANDREW P. EILERMAN, D.O.

Dr# _____

PATIENT HEALTH HISTORY – PEDIATRIC

PATIENT NAME: _____ DOB: _____ Today's Date: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

PLEASE ANSWER ALL QUESTIONS BELOW TO THE BEST OF YOUR ABILITY

PEDIATRIC/TODDLER/ADOLESCENT SOCIAL INFORMATION

Child lives with _____ Number of: Brothers _____ Sisters _____

Does the child exercise regularly? N Y Sports activity(s): _____

Does the child drink city or well water? City Well Other _____ Was the home the child lives in built before 1960? N Y

Has your ADOLESCENT ever used nicotine? N Y If yes, what type (cigarettes, chew) & how much per week? _____

Do either of the child's parents use nicotine? Mother Father Other

Is there ANY exposure to cigarette smoke (Sibling/Grandparent/Sitter)? N Y

Does the child drink caffeine (Soda/Tea/Coffee)? N Y What type & how often? _____

Does the child use or has ever used illegal drugs? N Y What type & how often? _____

Are there guns in the home? N Y Are there pets in the home? N Y Type of pet (dog/cat/hamster) _____

If over 16, does the child have a driver's license? N Y Is the child sexually active? N Y

Menarche at what age? _____ Any problems with cycle? _____ On Birth Control? N Y Type _____

Is the child up to date on all immunizations N Y What is missing? _____

PAST MEDICAL HISTORY ✓ Check any with which the child has been diagnosed:					
<input type="checkbox"/>	ADD	<input type="checkbox"/>	Developmental Delay	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Stomach Disorders
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	UTI's
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Eating Disorders
<input type="checkbox"/>	Other:	<input type="checkbox"/>		<input type="checkbox"/>	

PAST SURGICAL HISTORY ✓ Check any surgical procedures the child has had:					
<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	Other Surgical Procedure(s):
<input type="checkbox"/>	Adenoidectomy	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	
<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	Ear Tubes	<input type="checkbox"/>	

CHILD'S FAMILY HISTORY			
Has any member of the immediate family (including parents, grandparents or siblings) ever had or been diagnosed with:			
<input type="checkbox"/> Adopted – No information available			
DISEASE CONDITION	FAMILY MEMBER & AGE WHEN DIAGNOSED		
<input type="checkbox"/>	Cancer(s)—Include Type of Cancer		
<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	Heart Disease		
<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	Strokes or TIA's		
<input type="checkbox"/>	Mental Disease (Anxiety or Depression)		
<input type="checkbox"/>	Drug Addiction		
<input type="checkbox"/>	Alcohol Addiction		
<input type="checkbox"/>	Glaucoma		
<input type="checkbox"/>	Bleeding Disorders		
<input type="checkbox"/>	OTHER:		