THOMAS CHITTENDEN
HEALTH CENTER

Child/Adolescent Health History

Patient Name: _____ DOB: _____

To provide your child or adolescent with the most appropriate care, it is important that we know their detailed health history. Please take a few moments to fill out this Health History form, so that we can get to know them. Please note that if you have signed them up for our Patient Portal, you can bypass this form and enter the information directly into the electronic health record!

MEDICATIONS – Please bring all medication bottles with you to the first visit

*** Please include prescription and non-prescription medications used on a regular basis (Including vitamins, supplements, alternative medicines, etc.)

Use extra sheet if needed.

Medication Name	Strength	Frequency	Used for

ALLERGIES / SENSITIVITIES – Please list all reactions. Use extra sheet if needed

Medication/Substance	Reaction	Date

MEDICAL CONDITIONS – Please list all current or pertinent past medical conditions

Condition	Date		Condition	Date

SURGICAL HISTORY

Surgery	Date		Surgery	Date

Family Health History

	Deceased?	Age at death	Diabetes	Heart disease <65yo	Stroke	High blood pressure	Mental illness/mood disorder and type	Cancer (and type)	Other
Father	☐		☐	☐	☐	☐			
Mother	☐		☐	☐	☐	☐			
Paternal Grandfather	☐		☐	☐	☐	☐			
Paternal Grandmother	☐		☐	☐	☐	☐			
Maternal Grandfather	☐		☐	☐	☐	☐			
Maternal Grandmother	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			

PERSONAL HISTORY

Living situation: ◯Lives with both parents together ◯ Shared custody, lives with each parent separately ◯Lives exclusively with one parent ◯Other: _____

Current household members (check all that apply): ☐Mother ☐Father ☐Step-mother ☐Step-father ☐Brother(s) ☐Sister(s) ☐Grandmother ☐Grandfather ☐Other: _____

Main adult contact for child/adolescent: _____

Relationship to child/adolescent: ◯ Mother ◯ Father ◯ Other: _____

Address: _____

Contact phone number: _____

Do you have smoke alarms in your home: ◯No ◯Yes

Do you have carbon monoxide detectors in your home: ◯No ◯Yes

Is anyone in the home a smoker: ◯No ◯Yes If yes, then who: _____

Do you have any guns in your home: ◯No ◯Yes If yes, are they secured in some way (locked in a gun safe, trigger locks, separate from ammunition), and how: _____

School attended (if applicable):_____ Grade in school: _____

Does your child/adolescent follow any specific diet (ie vegetarian, vegan, low carb, etc)? ◯No specific diet plan ◯Yes
Type: _____

How much activity does your child/adolescent get in a day: ◯1 hour or more ◯ 30-60 minutes ◯15-30 minutes ◯Less than 15 minutes

Does your child/adolescent wear a seatbelt in the car, or in a car seat if applicable? ◯Never ◯ Sometimes ◯Always

Does your child/adolescent wear a bike helmet when they ride a bicycle? ◯Never ◯Sometimes ◯ Always

Do your child/adolescent currently wear or use (check all that apply): ☐eye glasses for distance ☐eye glasses for reading ☐contact lenses ☐hearing aids ☐wheel chair ☐orthopedic brace ☐other: _____

Health Maintenance

Test	Date	Results (if known)
Last well child/adolescent exam		
Dental visit		
Eye visit		
Cholesterol/lipid screening		
Diabetes/sugar screening		

Immunization Status

Has your child/adolescent had all of their childhood immunizations? ◯No ◯Yes ◯Unsure

Please attach a copy of immunization record, or complete a Records Release form for a previous health care provider who may have the records.

Thank you for completing your Health History form!