Health History Form
CHILD/ADOLESCENT

SISTERSVILLE
RURAL HEALTH CLINIC

Name (First, Middle, Last)	Date of Birth	Social Security Number	Sex

Address	City, State, & Zip

What is the reason for your visit today?

Who was your previous Physician?

Please list any chronic medical problems: (Diabetes, High Blood Pressure, depression, etc)

Birth History: (please circle)

Vaginal Delivery Casesarian Section	How many getational weeks at delivery?
If Caesarian what was the reason?	Did patient go home within 3 days of birth? YES NO

Immunizations

Are immunizations up to date? YES NO	(If older than 11) Have you had the following	
Have you ever had Chicken Pox? YES NO	Tdap YES NO	Menactra YES NO
When was your last seasonal flu shot?	Gardasil YES NO	Tetanus Booster YES NO

Please list any current medications: (prescription, over-the-counter, herbal)

Please list any medication or food allergies

Please list any surgeries or hospitalizations (Dates if Possible)

Please list any medical problems in each of the following family members:

Mother:	Father:
Brothers/Sisters:	Children:
Please list any other family members with heart disease:	Please list any other family members with diabetes:
Please list any family members with cancer:	Other:

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Rogelio Bantug, MD
Amanda Nichols, MD
Gary Nichols, MD
Kate Grimm, ACNP-BC
Susie Carr, FNP-BC

Does anyone in household smoke?	YES	NO	If yes…How many packs/day?			How many years?
Do you smoke?	YES	NO	If yes…How many packs/day?			How many years?
Do you use other tobacco products?	YES	NO	If yes…How much/day?			How many years?
Do you use alcohol?	YES	NO	Rarely	Occasionally	Weekly	Daily
Do you exercise?	YES	NO	Rarely	Occasionally	Weekly	Daily
Please list type of exercise:						

Are you having any of the following symptoms?
(Plese circle the appropriate response)

Fever	YES	NO	Cough	YES	NO
Chills	YES	NO	Nausea	YES	NO
Weight Loss	YES	NO	Diarrhea	YES	NO
Visual Changes	YES	NO	Burning with Urination	YES	NO
Runny Nose	YES	NO	Joint Pain	YES	NO
Chest Discomfort	YES	NO	Numbness	YES	NO
Shortness of Breath	YES	NO	Rash	YES	NO