ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

PEDIATRIC / ADOLESCENT HEALTH HISTORY

For patients ages 5–17. To be completed by a parent or legal guardian prior to the first visit.

PATIENT INFORMATION

Child's Full Name: _____ **Date of Birth:** _____

Preferred Name: _____ **Sex Assigned at Birth:** _____

Parent / Guardian Completing This Form: _____

Relationship to Child: _____

Primary Pharmacy (name & location): _____

BIRTH & EARLY HISTORY

Gestational Age at Birth (weeks): _____ **Birth Weight:** _____

☐ Full-Term Delivery ☐ Preterm Delivery ☐ Complications During Pregnancy or Delivery

If complications, please describe: _____

☐ NICU Stay Required

If yes, reason & length of stay: _____

DEVELOPMENTAL HISTORY

Please note any concerns with your child's development in the following areas.

☐ No Concerns ☐ Speech / Language ☐ Gross Motor (crawling, walking) ☐ Fine Motor (grasping, writing)

☐ Social / Emotional ☐ Learning / Academic ☐ Behavior ☐ Other: _____

Please describe any concerns noted above: _____

SCHOOL INFORMATION

School Name: _____ **Grade:** _____

☐ No Learning or Behavioral Concerns at School ☐ IEP / 504 Plan in Place ☐ Other Accommodations

Please describe: _____

SURGICAL HISTORY

List any prior surgeries or procedures, with approximate year.

Procedure	Year	Surgeon / Hospital (if known)

HOSPITALIZATIONS

Reason for Hospitalization	Year	Hospital (if known)

ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

CURRENT MEDICATIONS

Medication	Dose	Frequency	Prescribing Provider

ALLERGIES

Allergen	Reaction

IMMUNIZATIONS

Please attach a copy of your child's immunization record if available.

Immunization record attached? _____

☐ Up to Date per Pediatric Schedule ☐ Behind Schedule / Catching Up

The physicians at Ellenbecker Personalized Medicine are strong advocates of childhood immunization. We are unable to provide care in our office to children who are unvaccinated by parental choice, as this poses a potential risk to our other patients and runs contrary to our own medical beliefs.

PAST MEDICAL HISTORY / DIAGNOSES

Please check any conditions your child has been diagnosed with.

☐ Asthma ☐ Eczema / Skin Conditions ☐ Food Allergies ☐ Seasonal Allergies

☐ ADHD ☐ Anxiety / Depression ☐ Autism Spectrum ☐ Seizures

☐ Frequent Ear Infections ☐ Diabetes ☐ Heart Condition ☐ Other: _____

Condition	Year Diagnosed	Notes

FAMILY HISTORY

Please note health conditions affecting immediate family members, with particular attention to cancer, diabetes, heart disease, and any known genetic or hereditary conditions.

ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

Relation	Living? Age / Age at Death	Cancer (type)	Diabetes	Heart Disease	Other Conditions

Known genetic conditions in the family: _____

SOCIAL HISTORY

For adolescent patients. Some of these questions may be asked privately during the visit.

Tobacco / Nicotine / Vape Use:

☐ Never ☐ Has Tried ☐ Current Use

Alcohol Use:

☐ Never ☐ Has Tried ☐ Current Use

Recreational / Other Drug Use:

☐ Never ☐ Has Tried ☐ Current Use

Hobbies, Sports, & Regular Physical Activity: _____

_____

Typical Sleep (hours/night): _____

Screen Time (hours/day): _____

Diet / Nutrition:

Any concerns with eating habits, appetite, or weight? _____

ADDITIONAL INFORMATION

Is there anything else about your child's health you would like us to know?

_____

_____

Parent / Guardian Signature: _____ **Date:** _____