Health History Summary

As you make the transition from pediatric to adult health care, you will be assuming more responsibility for your health care. When you go to your new adult doctor (or other health care provider), you will be asked about major health events in your life. ***Have a parent help you fill out this form*** *and take it with you when you go to your new adult care doctor (or other health care provider) and you will be prepared for the questions that you will be asked.*

How would you describe your overall general health? (Please circle one and add comments if you want to)

Fair Good Excellent

What are your special health care needs? Is there anything in particular that your doctor needs to know about your special needs?

As a child and teenager, what were your major health problems?

What medications are you **currently** taking?

Medications:	What is it taken for?	How Much? (Dose)	How Often? (Schedule)

Allergies or adverse reactions to medications

Are there any medications that you have taken that have caused you problems?

Medication	Reasons no longer taking medication

Food or other allergies: (include bee stings)

Food or substance	Reaction and Treatment

Past medical history:

Your birth weight: _____ Were you born early? _____ If so, how many weeks early? _____

Did your mother have any problems with her pregnancy or delivery of you?

Were you hospitalized at the time of your birth? _____ If yes, how many days?____ or weeks?____

What problems did you have at birth?

Please list any serious illnesses you have had and any injuries that included loss of consciousness.

Please list hospitalizations and surgeries you have had and include the dates and places.

Personal health history: Have YOU ever had the following:

Condition:	Yes	Age
Anemia		
Asthma		
Blood Transfusion		
Cancer		
Constipation		
Diabetes		
Ear Infections		
Eating Problems		
Heart Disease		
Hepatitis		
Seizures (Epilepsy)		
Tuberculosis		
Attention Deficit Disorder		

Condition:	Yes	Age
Depression		
Suicide attempt		
Conduct Disorder		
Anxiety		
Learning Disability		
Developmental Delay		
Eating Disorder		
Other Conditions not Listed:		

If the answer is yes to any of the above conditions please use this space to make any additional comments about the conditions. **For individuals with seizures,** describe the seizures and include how often the seizures occur, how long they last, and when was your last one?

What tests have previously been done for these conditions, what were the results, and where were they done? (MRI? CT? EEG? EKG? Genetic Testing? Blood Tests? Psychological Testing?)

What treatments have been tried for these conditions and what was the most successful?

Are the conditions the (please circle one): (same) (improving) (getting worse)

Resource Information:

School:_____ Grade in School: _____

Do you have an Individual Education Plan (IEP)?_____ Do you have a 504 plan? _____

Name of contact person at school_____ Telephone:_____

Do you use Vocational Rehabilitation services? _____Contact person at VR _____

Recent medical records:

List the name, address, and telephone number of any doctors or other health care provider who have the latest medical records about your health conditions.

Name	Specialty	Address	Telephone #

Other resources:

List the name, address, & telephone number of any other person that has worked with you in regard to your health condition in the past two years (such as a physical therapist, pharmacist, medical supply house, caseworker, school nurse, etc.).

Name	What They Do	Address	Telephone #

Your immunization dates: (Or attach a copy of your immunization record)

DPT/DT	1.	2.	3.	4.	5.
TD	1.	2.	3.	4.	5.
OPV	1.	2.	3.	4.	5.
MMR	1.	2.			
HIB	1.	2.	3.	4.	
Hep B	1.	2.	3.	4.	
Varicella	1.	2.			

Family Health History: Have any of your blood relatives had the following:

Condition:	Relation
Anemia	
Breast Cancer	
Cancer (Other)	
Diabetes	
Heart attack	
High Blood Pressure	
High Cholesterol	
Seizures	
Sickle Cell Anemia	
Stroke	
Thyroid Problems	
Tuberculosis	

Condition:	Relation
ADD/ADHD	
Alcoholism	
Depression	
Drug Abuse	
Learning Disability	
Manic Depressive	
Suicide	
Schizophrenia	
Other Conditions?	

Comments:

Insurance Coverage Information:

Insurance	Policy number	Telephone number

Do you receive social security income (SSI)?	YES	NO
Do you receive medical benefits through the SSI program?	YES	NO

Emergency Contacts:

Name	Relationship	Telephone numbers
		(W) (H)
		(W) (H)

Activities of Daily Living

	YES	NO
Are you visually impaired?		
Do you wear glasses or contacts?		
Are you deaf or hard of hearing?		
Do you use a hearing aid?		
Do you have any speech problems?		
Do you use sign language?		
Is English your preferred language? If no, what language do you speak?		
Can you walk?		
Do you use a walker?		
Do you use a wheelchair?		
Do you routinely wear medic alert identification?		

What other aids do you use to accomplish daily activities?

Are there any restrictions to your daily activities? (Can you drive an automobile? Do you need a computer to communicate? Etc.)

Your adult doctor will ask you questions in private about your sexuality, about drug and alcohol and cigarette use.