

BW PRIMARYCARE

Bridge to Wellness

Patient History Form, age 5-11

Name _____

Date of Birth _____ M or F

Current grade level _____

Parent/Guardian(s)

Prior Primary Care Provider or other specialists
seen within past 2 years

Allergies or reactions to medications?

Has the child been hospitalized for illness or
surgery? Provide dates as well.

Recent changes in family, living or school
situation?

Are you concerned about the child's mental
health or abilities in school? _____ If the
above answer is yes, please fill out a mental
health questionnaire- ask a staff member

Problems or concerns with any of the
following, either in the child or a family
member?

Heart

Lungs

Head/ears/nose/throat

Abdomen/Stomach/Intestines

Muscles or Joints

Nervous system

Depression or Anxiety

High blood pressure

High cholesterol

Diabetes

Thyroid disease

Cancer

Skin

Other

Family History Medical Problems

Mother

Father

Brothers/Sisters

Other Health History

Is there a smoker in the home?

Last dental appointment?

Last vision screen or eye doctor appointment?

Is there a family or household contact with **HIV, tuberculosis, Hepatitis C or any other infectious disease of concern?**

Are there any specific concerns you would like to address at this first appointment?

List current medications, with dose and frequency, and any other vitamins and/or supplements taken by the child

Do you have a copy of the **child's immunization record?** ____ If so, please bring to the appointment. If not, please ask us to make you a copy, or obtain from your prior provider.