

Total Sports and Family Care

Karen Allen, MD

Darla Cowart, MD

Brian Cost, MD

Jeff Garrard, MD

Under 14 Health Evaluation Form

Name: _____

Acct: _____

DOB: _____

Date: _____

Gender: Female Male

Race: Black/ African-American Asian Caucasian Native American/Alaskan Pacific Islander Other _____

Ethnicity: Hispanic/Latino Non Hispanic/Latino

IS CHILD IS 1 YEAR OF AGE OR OLDER: Y* N *If yes, skip boxed section.

IF UNDER 1 YEAR OLD

PREGNANCY PREGNANCY/DELIVERY INFO UNKNOWN

of living children: _____

Mother's age at birth: _____

Trimester Prenatal Care Began: 1 2 3

Vitamins: Y N Iron: Y N

MATERNAL COMPLICATIONS *Circle as needed*

Vaginal Bleeding	Flu-like illness or high temp
Anemia	Kidney or bladder infection
Hypertension	STDs
Rh Negative	Hepatitis (A, B, C)
Diabetes	TB or TB exposure
Premature labor	Lead/Chemical exposure
Dental disease	Injury/surgery/accidents

MATERNAL SUBSTANCE USE

OTC meds: _____

Prescriptions: _____

Tobacco: _____

Alcohol: _____

Street drugs: _____

Caffeine: _____

BIRTH/DELIVERY

Hospital Birthing Center Home

Hours of labor: _____

Term Premature (weeks): _____

Vaginal C-Section Forceps

Breech Multiple Birth other

NURSERY COURSE

Birth wt: _____ Length _____

Difficulty Breathing Transfusion

Jaundice req treatment Heart murmur

Infection Seizures

NICU # days: _____ Age at NICU Discharge: _____

Newborn blood screening done: Y N

Newborn Hearing test: Normal Abnormal

PERSONAL HISTORY *Circle as needed*

Imms up-to-date? Y N Records unavailable

Dental care current? Y N

Use tobacco? Y N How often? _____

Use alcohol? Y N How often? _____

Surgeries: _____

FAMILY MEDICAL HISTORY

Circle as needed

(Pertains to parents, siblings, grandparents) Unknown

Anemia/Blood Disorder	HIV
Heart Disease under 50	Immunosuppression
High Cholesterol	Dental Decay
Hypertention	Stroke
Tobacco use	Alcohol/Drug abuse
Cancer	Diabetes
Epilepsy/seizures	Hearing impaired
Kidney problems	TB
Physical/sexual abuse	Psychiatric disorder
Genetic disease	Domestic violence
Thyroid issues	Muscle/bone disease
Other:	_____

CURRENT PROBLEMS

Circle all that apply

Abdominal pain	Athlete's Foot	Dizzy spells
Loss of appetite	Memory loss	Fainting spells
Indigestion	Blood in urine	Sweating spells
Nausea	Painful urinating	Anemia
Vomiting	Urinating more	Seizures
Heartburn	Breast problem	Wt gain
Diarrhea	Stiff joints	Wt loss
Constipation	Back pain	Lightheaded
Gas/Bloating	Swollen joints	Behavior issues
Hemorrhoids	Irreg heartbeat	Fevers
Painful swallowing	Chest discomfort	Vision change
Blood in stool	Sinus Problems	Hearing change
Cough	Ear problems	Anger
Short of breath	Neck Pain	Irritability
Hoarseness	Rash	Sleep issues
Wheezing	Numbness	Nervousness
Warts/moles	Bald spots	Fatigue
Sexual Issues	Vaginal irritation	Depression
Other:	_____	

Age periods started: N/A _____

Allergies: _____

Current Meds: _____