ARETE PROVIDER NETWORK
Arete Family Medicine - Anchorage

Patient name: ________________ Patient DoB: ______

Parent/guardian name(s): ________________________

Parent/guardian signature: ________________________

Patient Health History Questionnaire (Ages 5-11)

Today's date: ________

Medications/supplements (include name and dosage): ________________________

Allergies to medications/food (include reaction): ________________________

Surgical/hospitalization history (include month/year): ________________________

Family History (specify relation for each)

- ○ Asthma ________________
- ○ Attention deficit disorder ________________
- ○ Blood disorder ________________
- ○ Cancer (which type) ________________
- ○ Diabetes ________________
- ○ Heart disease before 55 ________________
- ○ High cholesterol ________________
- ○ Hypertension ________________
- ○ Kidney disease ________________
- ○ Mental illness/depression ________________
- ○ Sudden cardiac death ________________
- ○ Other: ________________

Social History

Grade/School: ________________

Parents relationship status: ________________

Names/ages of siblings: ________________

Others in the home: ________________

Pediatrician (if not with AFM-A): ________________

Vaccines up to date? ☐ Yes ☐ No

Any household members smoke? ☐ Yes ☐ No

Sports: ________________

Other interests: ________________

Medical History Diagnosed by a Healthcare Provider

- ○ Allergies
- ○ Anxiety/depression
- ○ Arthritis
- ○ Asthma
- ○ Attention deficit disorder
- ○ Autism
- ○ Birth defects
- ○ Broken bones
- ○ Cancer (type) ________________
- ○ Congenital heart disease/surgery
- ○ Diabetes
- ○ Ear infections (frequent)
- ○ Gait problems
- ○ GI problems
- ○ Head injury
- ○ Headaches
- ○ High cholesterol
- ○ Hypertension
- ○ Pneumonia
- ○ Reading problems/dyslexia
- ○ Reflux disease (GERD)
- ○ Seizures
- ○ Skin issues
- ○ Urinary tract infections
- ○ Vision problems
- ○ Other: ________________________

Provider initials: __________

09/23/19