EVANGELINE ROXAS-BUTLIG, MD, INC.

PEDIATRIC & TEEN CLINIC

Torrance Clinic:
1727 Crenshaw Blvd.
Torrance, CA 90501
(310) 373-7855

Carson Clinic:
1000 E. Dominguez St, Suite 110
Carson, CA 90746
(310) 715-7755

PEDIATRIC INITIAL HEALTH ASSESSMENT

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Nationality: _____

Last Well Child/Adolescent Exam _____ Date Medical History Obtained _____ Medical History Source _____

BIRTH HISTORY:

State, County Where Child Was Born _____ Pregnancy/Delivery Problems _____

Delivery Type _____ Postpartum Complications _____

Was Baby Discharged With Mother? ☐ Yes ☐ No Why? _____

Results of Hospital Nursery Hearing Screening: _____

MEDICAL HISTORY

Allergies to Food, Environment, or Medications _____

Hospitalizations _____

Surgeries _____

Injuries/Accidents _____

Significant Illnesses _____

Sexually Active ☐ Yes ☐ No If Yes, Method of contraception: _____

Sexually Transmitted Diseases ☐ Yes ☐ No If Yes, Describe: _____

CHILD HAS HAD:

☐ Chicken Pox Date and/or Age: _____ ☐ Mumps Date: _____

☐ Measles Date: _____ ☐ TB Date: _____

☐ Any Other Problems _____

PRESENT MEDICATIONS:

Prescription	OTC

FAMILY MEDICAL HISTORY:

☐ Alcoholism	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Anemia	☐ Drug Abuse	☐ Learning Disability	☐ Thyroid Problems
☐ Asthma	☐ Eczema	☐ Mental Retardation	☐ Tuberculosis
☐ Birth Defects	☐ Hay Fever	☐ Obesity	☐ Other
☐ Cancer	☐ Heart Disease	☐ Seizures	
☐ Depression	☐ High Blood Pressure	☐ Sickle Cell Disease/Trait	

Patient Name: _____ D.O.B: _____

SOCIAL / CULTURAL HISTORY

School Name: _____ Grade Level: _____

Language Spoken At Home: _____ Number of Family Members Living In Same House: _____

Primary Caretaker of the Child: _____

	Name	Occupation	Age
Mother:			
Father:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling			

ENVIRONMENTAL HISTORY

Alcohol Use:	☐ Yes	☐ No
Drug Use	☐ Yes	☐ No
Exposure to Tobacco Smoke	☐ Yes	☐ No
Tobacco Use	☐ Yes	☐ No