

18 and Over Yearly Check Up Form

Patient's Name _____Date of Birth _____

Parent/Guardian's Name _____

Patient Signature_____Date _____

In the past year, has the patient:

- Been hospitalized? ___ Yes ___ No If Yes, when and what for?

_____

- Had surgery? ___ Yes ___ No If Yes, when and what for?

_____

- Suffered a serious injury? ___ Yes ___ No If Yes, when and what for?

_____

- Had a concussion? ___ Yes ___ No If Yes, when and what for?

_____

- Visited a specialist? ___ Yes ___ No If Yes, when and what for?

_____

- Developed a food allergy? ___ Yes ___ No If Yes, when and what for?

_____

- Visited a foreign country? ___ Yes ___ No If Yes, when and what for?

_____

Update Family and Social History

- Does Mom or Dad have High Cholesterol? ___ Yes ___ No
- Have there been any changes in who lives in the home? ___ Yes ___ No
  (divorce, separation, death in the family, etc)
- Are there any smokers in the home? ___ Yes ___ No
- Does the patient have any new medication? ___ Yes ___ No
- Does the patient have any new medication allergies? ___ Yes ___ No
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TPG Pediatrics

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