Name FMP/SSN last DOB:

Email Address : Contact Phone Number:

11-18 YEAR VISIT

Do you have any specific concerns today? ____

____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/ Hospitalizations	Dates	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**	Example Circumcision		**Allergies** **Asthma** **Diabetes** **Heart Disease** **Obesity**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):**

Any hospitalizations, specialty care or ER visits since last appointment? ❑Yes ❑No Please specify ____________________________

Check if anyone in the family has had:

□ High Blood Pressure □ Diabetes □ Heart attack < 50 years □ Sudden Death □ Mental Illness

□ High Cholesterol □ Obesity □ Genetic or Metabolic Disease □ Long QT syndrome □ Hypertrophic Cardiomyopathy

Please list any known **allergies** you have (medication, food, latex) ____

Are you enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is your sponsor currently deployed? ❑ Yes ❑ No Is this visit **deployment** related? ❑ Yes ❑ No

Are your immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who do you live with?____

Do you attend: ❑ Public/private school ❑ Home-schooled (Grade : ___________)

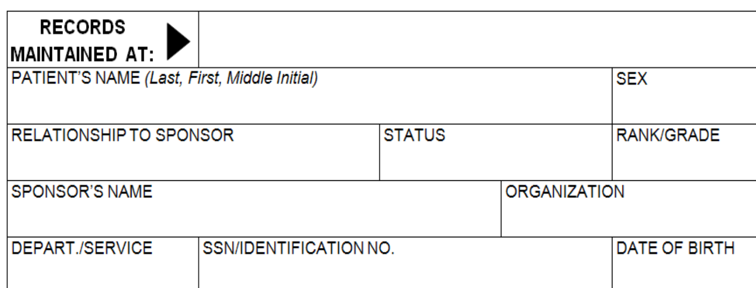
Does anyone in your family smoke? ❑ Yes ❑ No

Do you feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: ____________________________

Preferred language: ❑ English ❑ Other: _____________

Please See Reverse Side


RECORDS MAINTAINED AT:
PATIENT'S NAME *(Last, First, Middle Initial)* SEX
RELATIONSHIP TO SPONSOR STATUS RANK/GRADE
SPONSOR'S NAME ORGANIZATION
DEPART./SERVICE SSN/IDENTIFICATION NO. DATE OF BIRTH
STANDARD FORM 600 Overprint

Ethnic Origin ❑Filipino ❑Hispanic ❑ Asian/Pacific Islander ❑Southeast Asian ❑ Other ❑ Unknown ❑ Decline to Respond

Race ❑ Asian/Pacific Islander ❑ African American ❑ Caucasian ❑ Western Indian ❑ Other ❑ Unknown ❑ Decline to Respond

Are there cultural or religious considerations that affect your healthcare? ❑ Yes ❑ No ______________________________

Diet History:
Current Diet Less Than **5** Servings a day Of Fruits and/or vegetables ❑ Yes ❑ No

Current Diet High in Fat Content and Includes High Fat Snacks❑ Yes ❑ No

Current Diet High Fat and includes Frequent Fast Foods ❑ Yes ❑ No

Current Diet High Fat and Includes Fried Foods ❑ Yes ❑ No

Days a Week eating Breakfast _____ Days/week Having Dinner with Family _____

Eats Extra Large Portions ❑ Yes ❑ No High Sugar Beverages ❑ Yes ❑ No How many ounces per day? _____
Caffeinated Beverages ❑ Yes ❑ No How many per week? ____

Daily Milk Intake ___ounces per day Type of milk? ❑ Whole ❑ 2% ❑ 1% ❑ Skim

Exercise History:
Does you get at least one hour of physical activity at least 5 times per week? ❑ Yes ❑ No Type of activity: _____________

How many hours of exposure to TV/video games/computer time do you have per day? _______________________________

Do you have a TV or internet in their bedroom? ❑ Yes ❑ No

Do you have a history of:

□ Trauma

□ Fractures

□ Fainting during exercise

□ Head Trauma

□ Chest pain or discomfort

□ Exercise intolerance

□ Concussion

□ Palpitations

In the past week, have you had:

Fever	Yes/No	Duration?________	Cough	Yes/No	Duration?________
Headache	Yes/No	Duration?________	Wheezing	Yes/No	Duration?________
Congestion	Yes/No	Duration?________	Vomiting	Yes/No	Duration?________
Runny nose	Yes/No	Duration?________	Diarrhea	Yes/No	Duration?________
Earache	Yes/No	Duration?________	Abdominal pain	Yes/No	Duration?________
Eye discharge	Yes/No	Duration?________	Appetite Less	Yes/No	Duration?________
Sore throat	Yes/No	Duration?________	Rash	Yes/No	Duration?________

Other (describe)______________________________

Females only (if applicable): Last menstrual period __________________