

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone number: \_\_\_\_\_

Allergies: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Is child adopted?  Yes  No

Interpreter needed?  Yes  No \_\_\_\_\_

**PAST MEDICAL HISTORY**

**Prenatal History**

Birth weight: \_\_\_\_\_ Gestation: \_\_\_\_\_

Complications with Pregnancy/Delivery: \_\_\_\_\_

- None?.....  Yes  No
- Premature birth?.....  Yes  No
- Asthma? .....  Yes  No
- R.S.V.? .....  Yes  No
- Bronchiolitis? .....  Yes  No
- Allergic rhinitis? .....  Yes  No
- Hepatitis? .....  Yes  No
- Heart defects/heart disease? .....  Yes  No
- Seizures? .....  Yes  No
- Recurrent ear infections? .....  Yes  No
- Diabetes? .....  Yes  No

- Bladder infections?.....  Yes  No
- Drug-resistant organisms (MRSA/VRE)?  Yes  No
- HIV / AIDS? .....  Yes  No
- ADHD? .....  Yes  No
- Mental health? .....  Yes  No
- Behavioral problems?.....  Yes  No
- Learning problems?.....  Yes  No
- Acne? .....  Yes  No
- Eczema? .....  Yes  No
- Dental concerns? .....  Yes  No

Other health problems?.....  Yes  No \_\_\_\_\_

Hospitalizations? .....  Yes  No \_\_\_\_\_

Are immunizations on schedule?.....  Yes  No \_\_\_\_\_

Previous reaction to immunizations?...  Yes  No \_\_\_\_\_

**SURGICAL HISTORY**

- None?.....  Yes  No \_\_\_\_\_
- Appendectomy? .....  Yes  No \_\_\_\_\_
- Tonsillectomy? .....  Yes  No \_\_\_\_\_
- Adenoidectomy?.....  Yes  No \_\_\_\_\_
- Ear tube placement? .....  Yes  No \_\_\_\_\_

Other previous surgical procedures: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY

Condition	Relation	Age Diagnosed
Unknown? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Aneurysms? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Asthma? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bleeding tendencies? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Stroke? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Pulmonary embolism? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Heart problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
High cholesterol? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
High blood pressure? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cancer? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mental illness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sudden infant death syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Birth defects? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Genetic condition? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Drug abuse? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Alcohol dependency? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
HIV/AIDS? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Thyroid disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Tuberculosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other health problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Is child's father deceased? .....  Yes  No      Cause of death: \_\_\_\_\_ Age: \_\_\_\_\_

Is child's mother deceased? .....  Yes  No      Cause of death: \_\_\_\_\_ Age: \_\_\_\_\_

## SOCIAL HISTORY

With whom does the child live? \_\_\_\_\_ Total number of siblings: \_\_\_\_\_

Sibling's name	Relationship to patient	Birth date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

(continued...)

## SOCIAL HISTORY *(continued)*

Day care provider:  Home day care  Day care provider  Relative or friend  None

Religious or cultural practices we need to know to better serve child's needs?...  Yes  No

## HEALTH RISK PROFILE

### Latex Allergy Risk:

Allergic to latex? ..... Yes  No \_\_\_\_\_

Reaction to medical procedure? ..... Yes  No \_\_\_\_\_

Reaction to dental procedure? ..... Yes  No \_\_\_\_\_

Allergic to bananas? ..... Yes  No \_\_\_\_\_

Allergic to kiwi?..... Yes  No \_\_\_\_\_

Allergic to avocado? ..... Yes  No \_\_\_\_\_

Allergic to chestnuts? ..... Yes  No \_\_\_\_\_

Exposure to secondhand smoke?  No  Yes (If "yes," who and where?: \_\_\_\_\_)

### Pediatric Health Risk Prevention:

Bike helmet use? ..... Yes  No \_\_\_\_\_

Car seat/booster seat use? ..... Yes  No \_\_\_\_\_

Seatbelt use? ..... Yes  No \_\_\_\_\_

Smoke detectors in home? ..... Yes  No \_\_\_\_\_

Carbon monoxide detectors in home? .. Yes  No \_\_\_\_\_

### Pediatric Health Risk Hazards:

Lead exposure? ..... Yes  No \_\_\_\_\_

Guns in home? ..... Yes  No \_\_\_\_\_

Domestic violence?..... Yes  No \_\_\_\_\_

Alcohol use in home? ..... Yes  No \_\_\_\_\_

Drug use in home? ..... Yes  No \_\_\_\_\_

Dental visit during past year? ..... Yes  No \_\_\_\_\_

Do you feel safe at home? ..... Yes  No \_\_\_\_\_

Is someone threatening you? ..... Yes  No \_\_\_\_\_

Do you want to discuss abuse? ..... Yes  No \_\_\_\_\_