

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

- None?..... 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
- Menstrual problems? Yes No
- ADHD? Yes No
- Mental illness?..... 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? Yes No _____

(continued, over...)

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)*

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?: _____)

Tobacco use? Yes No _____

Prior tobacco use? Yes No _____

Alcohol use? Yes No _____

Recreational drug use? Yes No _____

Caffeine use? Yes No _____

Pediatric Health Risk Prevention:

Bike helmet 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 _____