PEDIATRIC PATIENT INFORMATION

Patient Name___________________

Address___________________

City__________ State__________ Zip__________

Home Phone___________________

Cell Phone ___________________

Email___________________

Sex ❑ M ❑ F Age _____ Birthday__________

IN CASE OF EMERGENCY, CONTACT

Name___________________

Relationship___________________

Contact Number ___________________

Mother's Name ___________________

Mother's Occupation ___________________

Mother's Phone ___________________

Mother's Email ___________________

Father's Name ___________________

Father's Occupation ___________________

Father's Phone ___________________

Father's Email ___________________

Who may we thank for referring you?

____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: ___________________

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: ___________________

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nausea/Vomiting

❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) ___________________

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech

❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? ___________________

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium

❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other ___________________

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night:______________________ Quality of sleep: ______________________

At what age did the child:

Respond to sound: ______________ Crawl: ______________ Hold head up: ______________

Stand: ______________ Sit unsupported: ______________ Walk unsupported: ______________

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Robiola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- ❑ Allergies
- ❑ Anemia
- ❑ Arm Problems
- ❑ Asthma
- ❑ Back Aches
- ❑ Bed Wetting
- ❑ Behavioral Problems
- ❑ Broken Bones
- ❑ Chronic Ear Aches
- ❑ Colds/Flu
- ❑ Colic
- ❑ Convulsions/Seizures
- ❑ Delayed Speech
- ❑ Diabetes
- ❑ Digestive Issues (constipation/diarrhea)
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Heart Trouble
- ❑ Hyperactivity
- ❑ Hypertension
- ❑ Juvenile / Rheumatoid Arthritis
- ❑ Joint Problems
- ❑ Leg Problems
- ❑ Neck Problems
- ❑ Neuritis
- ❑ Orthopedic Problems
- ❑ Paralysis
- ❑ Poor Appetite
- ❑ Ruptures/Hernias
- ❑ Sinus Trouble
- ❑ Tuberculosis
- ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As Scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

____

____

MEDICATIONS (list)

____

____

SURGERIES (list)

____

____

FAMILY HISTORY (list)

____

____

SIBLINGS

How many children do you have?______________________ Number of pregnancies: ______________________

Children's Ages:______________________ Are you currently pregnant? ❑ No ❑ Yes, I'm due: __________

Children's health concerns:______________________ Health concerns regarding this pregnancy? ______________

______________________ ______________________

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: ______________________ Witnessed: ______________________ Date: ______________________