Hillsborough Medical Assoc.

PEDIATRIC PATIENT INFORMATION

PATIENT INFORMATION

Name: _____ Date of birth: _____

Phone number: _____ Cell 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 (0 to 6 months only)

Mode of delivery: ❑Vaginal ❑Primary C/S-Labored ❑Vacuum ❑Primary C/C-No Labor ❑Forceps ❑Repeat C/S

Birth weight: _____ Gestation: _____

Complications with Pregnancy/Delivery: _____

Newborn Metabolic Screen results: ❑ Normal ❑ abnormal

Hearing Screen results: ❑ Pass ❑ Fail Date of hearing re-screen pass: _____ ❑ Referred: _____

Medical History

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
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 _____

Family History

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

Social History *(continued)*

Day car 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 _____

Smoking Status:

Current every day smoker ..... ❑ Yes ❑ No _____
Current some day smoker ..... ❑ Yes ❑ No _____
Former smoker ..... ❑ Yes ❑ No _____
Never smoker ..... ❑ Yes ❑ No _____
Smoker current status unknown ..... ❑ Yes ❑ No _____
Unknown if ever smoke ..... ❑ Yes ❑ No _____
Exposure to secondhand smoke ❑ No ❑ Yes (If "yes," who and where?): _____
Other tobacco use ..... ❑ Yes ❑ No _____
Alcohol use ..... ❑ Yes ❑ No _____
Recreational drug us ..... ❑ Yes ❑ No _____
Caffeine use ..... ❑ Yes ❑ No _____

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 _____