Calvary Pediatrics Pediatric Patient History

Child's Name _____ DOB _____ M F Date _____

PREGNANCY AND BIRTH

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? ___No ___Yes_____
3. Any medications/drugs other than vitamins & iron? ___No ___Yes_____
4. Delivery by ___Vaginal ___C-Section If C-Section why? _____
5. Was the baby born at term (>37 wks)? ___Yes ___No _____
6. Birth Weight _____ Birth Length _____ APGAR score _____ 1 minute _____ 5 minute
7. Did the baby have any problems while in the hospital? ___No ___Yes If yes, what kind? __Jaundice __Breathing Problem __Infection __Other_____

PAST MEDICAL HISTORY

1. Allergic reaction to foods, medications, insects, other? __No __Yes If yes, give name & reaction_____ _____
2. Any serious reactions to immunizations? __No ___Yes If Yes, which ones? _____
3. Any hospitalizations or surgeries? __No __Yes If yes, Date & reason_____
4. Any serious injuries? __No __Yes If yes, date of injury _____
5. Does your child have or has she/he ever had: _ Frequent ear infections__ Frequent Strep throat__ Asthma__ Frequent diarrhea & Constipation __Any heart problems Or heart murmurs__ Seizures__ Eczema, hives or other Skin conditions__ Anemia or bleeding problem__Chicken Pox__Diabetes__ Vision/Hearing problems__ Frequent Headaches__ Pneumonia__Frequent urinary tract Infections__ Other significant problems If you answered Yes to any of the above, please explain below:

_____
_____
_____
_____
_____

FEEDING AND NUTRITION

1. How is your child's appetite? ___Good___Fair___Poor
2. Was there severe colic or any unusual feeding problems During the first 3 months? __No__ Yes _____
3. Was your child breast fed?__No__Yes If yes, for how Long? _____
4. Which of the following foods are included in your child's Diet? __Whole milk__Skim milk__2% milk __Meats __Vegetables__Juices__Fruits__Vitamins

DEVELOPMENT/BEHAVIOR

1. At what age did your child: sit alone _____ walk alone _____ toilet train _____
2. Was she/he saying words by 18 mo? ___Yes ___No
3. Trouble sleeping? ___No ___Yes _____
4. Grade in school? _____ Play sports? ___No ___Yes
5. Has she/he failed or repeated a grade in school? ___No ___Yes _____
6. Does she/he get along with other children? ___Yes ___No _____

SAFETY/ENVIRONMENT

1. Do you live in ___House ___Apt ___Mobile Home
2. Is there a working smoke alarm on each floor of the Home? ___Yes ___ No
3. Does your child always use a car seat/belt? __Yes __ No
4. Does your child always use a helmet when skating? ___Yes ___No Or bicycling? ___Yes ___No
5. Any concerns about lead exposure(old home/plumbing/ Peeling paint? ___No ___Yes _____
6. Are there smokers the child is exposed to? __No __Yes
7. Are there guns in the home? __No __Yes If yes, is it Securely locked? __Yes __No
8. Are there any pets at home? __No __Yes _____
9. Primary drinking water supply (including water used to Mix formula) __Well __City__Bottled

FAMILY HISTORY/SOCIALHISTORY

1. Please list all people living in the child's home:

Name	Age	Relationship	Health Problems

2. Are your child's parents: __Married __Unmarried
3. Father's Occupation: _____ Father's Employer: _____
4. Mother's Occupation: _____ Mother's Employer: _____
5. Child care situation: __Parents__Others (specify who & Hrs per day) _____
6. Check if a family member has had any of the following: __Asthma__ Diabetes on insulin__Diabetes not on Insulin__Seizures or epilepsy__ Immunodeficiency __Mental Retardation__Bleeding disorder__Deafness __Alcohol and/or drug abuse__Heart disease (before 50 Yrs old)__High blood pressure (before 50 yrs old)__ Tuberculosis__Liver Disease__Other

Please list below medications that are currently being taken on a regular basis (exclude vitamins):

Name Dosage

Permission to Discuss Protected Health Information & Authorization To Consent To Health Care

I hereby give my permission to the person(s) listed below to: 1) receive information about the care of the patient and /or 2) bring the patient to the office for medial treatment or lab services.

Name (First & Last)	Relationship	PHI Only	TREAT Only	TREAT &PHI

May we leave detailed messages on an answering machine? (appointment reminders, lab results, or referral appointment information) Yes ___ No___

If yes, what is that number? _____

Printed Name of Parent/Guardian Signature Date

Patient Password (Optional):_____ In order to obtain information by phone, the party calling the practice must share the patient password with the staff.