

# Patient Paperwork

Child Information	Child's Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>LAST</span> <span>FIRST</span> <span>M.I.</span> </div>
	Preferred Name: _____ Date of Birth: ____/____/____ Age: _____
	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Previous Doctor: _____

Parent/Guardian Info	Parent/Guardian Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>LAST</span> <span>FIRST</span> <span>M.I.</span> </div>
	Employer: _____ Occupation: _____
	Parent/Guardian Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>LAST</span> <span>FIRST</span> <span>M.I.</span> </div>
	Employer: _____ Occupation: _____

Current Medications		
MEDICATION	DOSE	HOW OFTEN

Does your child take any alternative or herbal medications?  \*Yes  No

\*If yes, please list \_\_\_\_\_

Allergies	
MEDICATION	REACTION

Does your child have any other allergies (latex, iodine, food or environment)?

\_\_\_\_\_

\_\_\_\_\_



*Only needs to be completed if the child is under 3 years of age*

Birth History

Delivery Type:  Vaginal  \*Cesarean

\*Why: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Was your child premature?  \*Yes  No \*If yes, how many weeks \_\_\_\_\_

Were there any problems with your child's delivery?  \*Yes  No \*If yes, please list: \_\_\_\_\_

Did your child have any unusual problems in the hospital such as oxygen, transfusions, or phototherapy for jaundice?  \*Yes  No \*If yes, please list: \_\_\_\_\_

Medical History

Any hospitalizations other than birth?  \*Yes  No \*If yes, please explain: \_\_\_\_\_

Any chronic illnesses?  \*Yes  No \*If yes, please explain: \_\_\_\_\_

Has your child seen a specialist?  \*Yes  No

\*If yes, please provide name and date of the most recent visit: \_\_\_\_\_

Review of Systems

System	Yes	No	Explanation of any problems
Lungs			
Heart			
Kidney/Urinary			
Bone/Muscle			
Gastrointestinal			
Brain/Nervous			
Genital			
Skin			
Ear/Nose/Throat			
Developmental concerns or learning problems			
Behavioral problems or eating disorders			
If female: age of first menstrual period			Age: _____



## Surgical History

Has your child had any surgeries?  \*Yes  No \*Please list surgery and approximate date:

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<b>Social History</b>	Any special communication needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Primary language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Child's primary language _____ Parent/Guardian(s)'s primary language _____ <i>*Language line is available to help us better communicate if English is not your first language. Please let the nurse know if you would like to use the language line.</i>
	Parents: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single
	How many people live in your home? _____ Adults _____ Children
	Are there smokers in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Any pets at home? <input type="checkbox"/> *Yes <input type="checkbox"/> No *If yes, please list: _____
	Are there smoke detectors in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are there carbon monoxide detectors in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your child attend: <input type="checkbox"/> Daycare <input type="checkbox"/> Preschool <input type="checkbox"/> Grade K-12 What school? _____

Sibling's Name	Date of Birth
1.	
2.	
3.	
4.	

List any medical conditions of the child's family members listed below:	
<b>Family History</b>	Mother
	Father
	Maternal Grandmother
	Maternal Grandfather
	Paternal Grandmother
	Paternal Grandfather
	Siblings
	Other Relatives (Aunt, Uncle, Cousin, etc.)

