PEDIATRIC PATIENT INFORMATION

Child's Last Name ______ First ______ Middle Initial ______

Date of Birth ______ Gender ☐ M ☐ F MRN ______ Phone ______

Home Address ______ City ______ State ______ Zip ______

Primary Care Physician ______ Phone ______

Address ______ City ______ State ______ Zip ______

Pharmacy of Choice ______ Phone ______

Address ______ City ______ State ______ Zip ______

MOTHER'S INFORMATION

Mother's Last Name ______ First ______ Middle Initial ______

SS# ______ Date of Birth ______ Phone ______

Email ______

Employer Name ______ Work Phone ______

Employer Address ______ City ______ State ______ Zip ______

FATHER'S INFORMATION

Father's Last Name ______ First ______ Middle Initial ______

SS# ______ Date of Birth ______ Phone ______

Email ______

Employer Name ______ Work Phone ______

Employer Address ______ City ______ State ______ Zip ______

INSURANCE

Primary Insurance Company ______ Phone ______

Insurance Address ______ City ______ State ______ Zip ______

Policy Holder's Name ______ Date of Birth ______

Group # ______ ID # ______

Secondary Insurance Company ______ Phone ______

Insurance Address ______ City ______ State ______ Zip ______

Policy Holder's Name ______ Date of Birth ______

Group # ______ ID # ______

PEDIATRIC HEALTH HISTORY

Today's date ______________________ Name ______________________

MRN ____________ Date of birth ____________

Preferred language ____________ Age ______ Gender ☐ M ☐ F Height ________ Weight ________

CHIEF CONCERN

What is the reason for the child's visit today? ______________________

Symptoms / complaints ______________________ Date of onset ____________

Is there a family history of this issue? ☐ Y ☐ N If this is an injury, how did it occur? ______________

Has your child seen any other doctor (including in an ER) for this? ☐ Y ☐ N

If yes, whom? ______________________

When? ____________ Treatment given ______________________

ALLERGIES ☐ No allergies

List anything your child is allergic to, including medications, environmental agents, food, etc.

Allergic to:	Reaction	Allergic to:	Reaction

MEDICATIONS

List any prescriptions, over-the-counter medications, and herbal/vitamin supplements your child is taking.

Name	Prescribed by	Why does your child take this?	Dose	Frequency

IMMUNIZATIONS

Name	Date	Name	Date

Child's name ______________________

MRN ____________ Date of birth ____________

SURGICAL HISTORY

List below any surgeries the child has had.

Surgery/Procedure	Year	Physician/Surgeon	Complications, if any

FAMILY HEALTH HISTORY

Please indicate any major illnesses or health conditions for family members.

	Age	Significant health issues		Age	Significant health issues
Mother			Sibling		
Father			Sibling		

SOCIAL HISTORY

Grade in School ____________ ☐ N/A ☐ Special Class ☐ Early Intervention

Employed/Occupation ______________________

Who lives at home with your child? ______________________

How often does your child exercise? ________ times per week School sports ______________________

REVIEW OF SYSTEMS

Has your child had any issues with:

Eyes	☐ Y	☐ N	Heart / Cardiac	☐ Y	☐ N	Muscle weakness	☐ Y	☐ N
Ears, nose, throat	☐ Y	☐ N	Lungs (breathing)	☐ Y	☐ N	Neurological	☐ Y	☐ N
Digestion	☐ Y	☐ N	Rash (skin problems)	☐ Y	☐ N	Numbness/Tingling	☐ Y	☐ N
Bladder	☐ Y	☐ N	Back pain	☐ Y	☐ N	Behavioral	☐ Y	☐ N
Bowel function	☐ Y	☐ N	Difficulty walking	☐ Y	☐ N	Psychological	☐ Y	☐ N

☐ Other (describe) ______________________

Does your child use assistive devices or orthotics? ☐ Y ☐ N Type and pattern of use ______________________

Physical Therapy?	☐ Y	☐ N	Frequency ____________	For what? ____________
Speech Therapy?	☐ Y	☐ N	Frequency ____________	For what? ____________
Occupational Therapy?	☐ Y	☐ N	Frequency ____________	For what? ____________
Medical Treatments?	☐ Y	☐ N	Frequency ____________	What kind? ____________

REVIEW/SIGNATURE

I have completed and reviewed the information on this form.

______________________ ____________

Parent/Guardian signature Date

______________________ ____________

Physician signature Date