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NEW PEDIATRIC PATIENT HISTORY INTAKE

Welcome to **High Tech Family Care**. In order for us to better serve you; please take the time to fill out this entire packet as accurately as possible so we can adequately address your health needs and/or concerns.

CHILD'S PERSONAL HISTORY

Name *(legal):* _____ Name (*preferred*): _____
Gender: ☐ Male ☐ Female Social Security #: ____ – _____ – ____
Date of Birth____/____/_____Age: _____ Birthplace: _____
Home Address: _____ City, State, Zip _____
Telephone: Home (___)_____Cell (___)_____
Ethnicity? ☐ White/Caucasian ☐ Black/AfricanAmerican ☐ Asian/PacificIslander ☐ Hispanic/Latino
☐ Native American ☐ Other _____

PARENT'S INFORMATION

Child's School_____
Parent's Name: _____ Child lives with:☐ Father ☐ Mother ☐ Both ☐ Other

Mother's Name: _____ Date of Birth_____/_____/_____Age:_____
Telephone: Home (___)_____Cell (___)_____
Email Address:_____
Occupation:_____
Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

Father's Name: _____ Date of Birth_____/_____/_____Age:_____
Telephone: Home (___)_____Cell (___)_____
Email Address:_____
Occupation:_____
Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

INSURANCE INFORMATION

Primary Insurance Carrier's Name: _____
Address: _____ City, State, Zip: _____
Insurance Member ID #: _____ Group #: _____
Policy Holder's Name: _____
Date of Birth_____/_____/_____ Social Security #: ____ – _____ – ____
Name & Address of Employer: _____
Relationship to Patient: _____

Your signature below indicates your consent for treatment of patient and your responsibility for payment of services provided. Thank you.

_____ _____
Guardian/Parent Signature Date:

Date of Last Examination_____
Child's Previous Pediatrician:_____Tel: (__)_____
Referred by:_____

ALLERGIES (DRUG OR FOOD):	Reaction(s)

REASON FOR THIS VISIT:

_____
_____
_____
_____

Current Medications	Dose	Times / Day
Current Herbs / Vitamins/ Supplements	**Dose**	**Times / Day**

BIRTH HISTORY: Past Medical, Surgical & Trauma History Personal And Family History

Mother's age at birth: _____Complications during pregnancy? ☐ NO ☐ YES
If "yes", explain:_____
Birth weight: _____ (*lbs*) _____ (*oz*) ☐ Bottle Fed☐ Breast Fed
Complications during/after birth? ☐ NO ☐ YES ***If "yes", explain***: _____
Was the baby full term? ☐ NO ☐ YES Delivery: ☐ Vaginal ☐ C-Section
Birth Hospital (for newborns only): _____

Past Medical History: (*Please check all that applies to your child)*

☐ Recurrent ear infections
☐ Recurrent sore throat
☐ Asthma
☐ Heart murmur
☐ Seizures
☐ Eczema
☐ ADHD/ADD
☐ Autism Spectrum
☐ Allergies
☐ Diabetes
☐ Down Syndrome

Provided immunization record? ☐ NO ☐ YES Are immunizations current? ☐ NO ☐ YES
Ever been seen by a specialist? ☐ NO ☐ YES ***If "yes" explain***: _____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY *List prior illnesses, injuries, hospitalizations, surgeries, and/or traumas:*	
Condition	**Date(s)**

Last Dental Visit:_____

Any additional important health history:

_____

_____

_____

_____

SOCIAL HISTORY:

Does anyone in the house smoke? ☐ NO ☐ YES ***If "yes," who?*** _____
Any pets? ☐ NO ☐ YES ***If "yes," what type of pets?*** _____
Is the child enrolled in daycare? ☐ NO ☐ YES
Is the child enrolled in school? If so, current grade level: _____ Failed/failing grades? ☐ NO ☐ YES
Problems in school? ☐ NO ☐ YES ***If "yes," explain***: _____
How many hours does your child sleep in a day? _____
Water supply at home: ☐ City/Municipal ☐ Well Are there any problems with your home? _____
What year was the home/apartment built? _____ Paint chipping on the wall? ☐ NO ☐ YES
Any recent travel? ☐ NO ☐ YES ***If "yes," when/where***: _____
Language spoken at home: _____
Has your child been exposed to anyone who has been recently incarcerated, or had Tuberculosis?
☐ NO ☐ YES ***If "yes," explain***: _____

Does your child smoke?	☐ NO ☐ YES	Use drugs?	☐ NO ☐ YES
Drink alcohol?	☐ NO ☐ YES	Have history of depression?	☐ NO ☐ YES
Drink caffeine?	☐ NO ☐ YES	Suicide attempts?	☐ NO ☐ YES

DIET:

What type of milk does your child drink? ☐ Whole ☐ 2% ☐ Skim ☐ Formula (type) _____
How much milk is typically consumed in 24 hours? _____
How many ounces of juice or soda does your child drink per day? _____
Does your child eat non-food materials (dirt/paper, etc)? ☐ NO ☐ YES If yes, explain: _____
Any concerns about your child's diet? ☐ NO ☐ YES ***If "yes," explain***: _____

SAFETY:

Do you have a smoke detector? ☐ NO ☐ YES What is your water heater temperature? _____
Is your home child proof? ☐ NO ☐ YES Any guns in the house? ☐ NO ☐ YES
Does home have a swimming pool? ☐ NO ☐ YES
What child-accessible medications do you have in your medicine cabinet? _____

FAMILY HISTORY:

Does the child's mother/father have any medical problems? ☐ NO ☐ YES ***If "yes," explain***: _____

List all children in the home:

Name _____age: _____ ☐ male ☐ female
General health status: _____
Name _____age: _____ ☐ male ☐ female
General health status: _____
Name _____age: _____ ☐ male ☐ female
General health status: _____
Name _____age: _____ ☐ male ☐ female
General health status: _____

Are there any deceased siblings? ☐ NO ☐ YES ***If "yes," explain***: _____

Has any blood relative ever had the following?

Cancer, including Leukemia	☐ NO ☐ YES	If "yes" who? _____
Tuberculosis	☐ NO ☐ YES	If "yes" who? _____
Diabetes	☐ NO ☐ YES	If "yes" who? _____
Heart Trouble	☐ NO ☐ YES	If "yes" who? _____
Heart Attack	☐ NO ☐ YES	If "yes" at what age? _____
High Blood Pressure	☐ NO ☐ YES	If "yes" who? _____
Stroke	☐ NO ☐ YES	If "yes" who? _____
Epilepsy	☐ NO ☐ YES	If "yes" who? _____
Bleeding Disorder	☐ NO ☐ YES	If "yes" who? _____
Asthma	☐ NO ☐ YES	If "yes" who? _____
Allergies	☐ NO ☐ YES	If "yes" who? _____
Migraine Headaches	☐ NO ☐ YES	If "yes" who? _____
Alcoholism	☐ NO ☐ YES	If "yes" who? _____
Anemia	☐ NO ☐ YES	If "yes" who? _____
Mental Illness	☐ NO ☐ YES	If "yes" who? _____
Suicide	☐ NO ☐ YES	If "yes" who? _____
Birth Defects	☐ NO ☐ YES	If "yes" who? _____
Sudden Death	☐ NO ☐ YES	If "yes" who/cause of death? _____
SIDS	☐ NO ☐ YES	If "yes" who? _____
HIV/AIDS	☐ NO ☐ YES	If "yes" who? _____
Other Serious Disease	☐ NO ☐ YES	If "yes" who/what? _____

GROWTH & DEVELOPMENT

At what age did your child sit up alone? _____
At what age did your child start walking? _____
At what age did your child start talking? _____
How does your child compare to other children his/her age? _____
_____

EMERGENCY CONTACT *(When parent/guardian is unable to be reached)*			
NAME *(list at least 3 contacts)*		**PHONE**	**RELATIONSHIP**
1.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
2.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
3.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
Advance Directive: ☐ Full code *or* ☐ Do Not Resuscitate			

This history record has been designed to facilitate our patient's continuity of care at **High Tech Family Care**. This is a confidential record. Information contained here will not be released without proper written authorization.

_____ _____

Physician Signature *Date Signed*

_____

Printed name of individual completing form

_____ _____

Signature of individual completing form *Date Completed*