Pediatric Patient Introduction

Date _____

SSN/HIC/Patient Id# _____

Child's Name _____
Last First MI

Mother's Name _____ H (___) _____ W (___) _____
Last First MI

Father's Name _____ H (___) _____ W (___) _____
Last First MI

Address _____ City _____ State _____ Zip _____

Birth Date ____/__/____ Age _____ Birth Weight _____ Current Weight _____

Sex _____ M _____ F No. of Siblings ___ Birth Length _____ Current Length _____

Type of Birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____

Home_____ Birthing Center _____ Hospital _____

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

APGAR Scores _____ _____

Was There Presence at Birth of:

_____ Jaundice (Yellow)

_____ Cyanosis (Blue)

Congenital Anomalies / Defects _____

Infant Feeding: Breast _____ Bottle _____ Formula _____

No. of Hours of Sleep Per Night ___ Quality of Sleep: Good _____ Fair ____ Poor ___

Obstetrician / Midwife: _____

Pediatrician / Family MD: _____

Date of Last Visit to MD _____ Purpose _____

Immunization History: _____

Purpose of this Appointment: _____

Has Your Child Ever Been Treated on an Emergency Basis? _____

Describe: _____

Insurance / Billing Information _____ Policy # _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son / daughter (upon approval of parent or guardian)

Signed _____ Witnessed _____ Date _____

I realize that I am responsible for all fees charged by this clinic and that I pay for all services as they are performed. X-rays remain the property of this clinic.

Date _____ Signature _____

Pediatric Case History

Pregnancy History: _____

_____

_____

_____

_____

Delivery/Birth History: _____

_____

_____

_____

_____

Developmental History

At what age did the child:

_____	Respond to sound	_____	Crawl
_____	Follow object with his/her eyes	_____	Stand
_____	Hold head up	_____	Walk alone
_____	Sit alone		

Childhood Diseases:

_____	Chicken Pox	_____	Rubella
_____	Mumps	_____	Rubeola
_____	Whooping Cough	_____	Measles

Has this child ever suffered from:

□ Dizziness	□ Backache	□ Heart trouble	□ Chronic earaches
□ Diabetes	□ Tuberculosis	□ Hypertension	□ Colds/Flu
□ Arthritis	□ Headache	□ Asthma	□ Allergies
□ Neuritis	□ Digestive disorder	□ Sinus trouble	□ Constipation
□ Anemia	□ Rheumatic fever	□ Orthopedic problem	□ Diarrhea
□ Poor appetite	□ Hyperactivity	□ Sugar concentration	□ Behavior problem
□ Bed wetting	□ Convulsions	□ Paralysis	□ Muscle jerking
□ Fainting	□ Walking problem	□ Broken bones	□ Ruptures/Hernias
□ Neck problems	□ Arm problems	□ Leg problems	□ "Growing pains"
□ Joint problems	□ Blood disorders	□ Stomach aches	□ Other

Present History: _____

_____

_____

_____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____