Patient Information, Pediatric

NOTE: THIS IS A CONFIDENTIAL MEDICAL RECORD AND WILL NOT BE RELEASED WITHOUT YOUR AUTHORIZATION.

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

Birth Date: _____ Sex: _____

Year in School _____

Birth Place: _____ Birth Type: ❑ Hospital ❑ Home ❑ Birth Center

Mothers Name: _____ Occupation: _____

Fathers Name: _____ Occupation: _____

Was child adopted? ❑ Yes ❑ No If YES, at what age and if from another country please state

_____

Spiritual Practice: ❑ Yes ❑ No If Yes, please indicate which belief system: _____

Names and ages of living brothers and sisters:

Name	Age

Pregnancy History

Number of pregnancies before this one: _____ Pregnancy Length (weeks): _____

Number of months before prenatal care started: _____

Were there any of the following illnesses or problems:

- ❑ Rubella (measles)
- ❑ Bleeding
- ❑ Swelling
- ❑ Excessive Weight gain
- ❑ Accidental/injury
- ❑ High blood pressure
- ❑ Sugar in urine
- ❑ Other Infections*

*Please list: _____

Birth Information

How long was labor? _____ Was labor induced? ❑ Yes ❑ No

Number of months before prenatal care started: _____

At delivery (tick all that apply):

- ❑ Breech (feet or bottom first)
- ❑ VBAC
- ❑ Resuscitated
- ❑ Other*
- ❑ Cesarean section
- ❑ Breathed & cried immediately
- ❑ In oxygen

*Please list: _____

Did baby require… (Tick all that apply):

- ❑ Special nursery
- ❑ Blood transfusion
- ❑ Antibiotics
- ❑ Other*

*Please list: _____

Birth Weight: _____ Length: _____ Apgar Score: _____

Discharge Weight: _____ Length of hospital stay: _____

Did baby receive…? (Tick all that apply)

- ❑ Vitamin K
- ❑ Hepatitis B vaccine
- ❑ Newborn screening tests

Infant Nutrition

Breast milk? _____ Duration: _____

Problems with…? (Tick all that apply):

- ❑ Vomiting
- ❑ Diarrhea
- ❑ Uses pacifier
- ❑ Colic
- ❑ Allergies
- ❑ Uses bottle

Solid food? ❑ Yes ❑ No Age when started: _____ What foods? _____

_____

Sleep and Elimination

Bowel movements / day? _____ Urination per day: _____

How does the child sleep? Where? With whom?

_____

Shared room or bed? Crib? Co-sleeper? Bunk bed? Tummy or back?

_____

Typical Bedtime: _____ Wake time: _____ # waking's / night: _____

Naps: _____ Sleep Problems: _____

Medical History

Breast milk? _____ Duration: _____

Problems with…? (Tick all that apply and specify age):

❑ Measles, Rubella	❑ Heart Disease	❑ Rheumatic Fever	❑ Hepatitis
❑ Anemia	❑ Allergies/Hay fever	❑ Convulsions/seizures	❑ Pneumonia
❑ Mumps	❑ Whooping Cough	❑ Strep throat	❑ Asthma
❑ Chickenpox	❑ Scarlet Fever	❑ Ear Infections	❑ Eczema

Has your child ever been injured? _____
Age *Injury*

Any loss of consciousness or concussion? _____
Age *Reason*

Any Accidental poisoning? _____
Age *Substance*

Has your child ever had surgery? _____
Age *Type of surgery*

Has your child ever been hospitalized other than the above? _____
Age *For what?*

Has your child ever had a blood transfusion? _____
Age *Reason*

Has your child worn (tick all that apply)?

❑ Glasses ❑ Dental braces ❑ Corrective shoes

❑ Contact Lenses ❑ Leg Braces ❑ Orthotics in shoes

Medications and Supplements:
List Vitamins, minerals, herbs, homeopathic remedies presently taken, with dosage:

Does your child have allergies to any of the following?

Drugs

Foods

Environment

Tick if your child has any of the following (Tick all that apply):

- ❑ Frequent headaches
- ❑ Pink eye
- ❑ Trouble hearing
- ❑ Poor appetite
- ❑ Chronic cough
- ❑ Heart murmur
- ❑ Signs of sexual development or sleep walking
- ❑ Stuffy nose most of time
- ❑ Excessive weight gain
- ❑ More than two earaches a year
- ❑ Crossed eyes
- ❑ Excessive thirst
- ❑ More than 6 colds a year
- ❑ Trouble hearing
- ❑ Frequent diarrhea or constipation
- ❑ Frequent urination or accidents

Other concerns?

Child Development

At what age did your child first…?

Sit: Walk: Feed self:

Talk: Dress self: Become toilet trained:

School age child:
Current Grade: Days missed this year:

School Problems?

❑ Reading ❑ Writing ❑ Behavior ❑ Special needs

Are there problems at home? If so please describe:

Immunizations and Screening:

- ❑ Immunizations up to date on standard schedule
- ❑ Selective immunizations and/or delayed schedule ***If so, please provide a copy of immunization record**.

Siblings and health related issues if any:

_____

Family Health History

Age and Disease *or* Cause of Death

Family Member *Age* *Disease / major health illness(es)*

Mother _____

Maternal Grandmother _____

Maternal Grandfather _____

Father _____

Paternal Grandmother _____

Paternal Grandfather _____

Cousins and if so, what side? _____

Aunts / Uncles and if so, what side? _____

Parent / Guardian Contact Information

Full Name: _____
Last *First* *M.I.*

Address (if different from child) : _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

General Information

[*Optional*] Please tell us how you found out about our office or who you were referred by:

- ❑ Friend
- ❑ Internet
- ❑ Referral*
- ❑ Newspaper
- ❑ Other*****

*Please tell us who referred you so we can thank them! _____

Declaration (Please read and sign)

Parent / Guardian:

Thank you very much for choosing Summit Vitality to be a part of your child's and your family's health care team. By signing below you are giving Dr. Lexi Lain permission to perform non-invasive physical exams (if necessary), run necessary laboratory tests, and administer treatment plans for your child.

Parent or Guardian Name:
(Please Print): _____

Signature: _____ Date: _____