EDIATRIC PATIENT INTRODU ION

CHILD'S NAME: _____ MOTHER'S NAME: _____
LAST FIRST MIDDLE LAST FIRST MIDDLE

CASE NUMBER: _____ FATHER'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

BIRTH DATE: ___ ___ ___ AGE: ___ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

SEX: _____ 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 SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

OBSTETRICIAN / MIDWIFE: _____
NAME LOCATED AT

PEDIATRICIAN / FAMILY MD: _____
NAME LOCATED AT

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 IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (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 WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

DATE: _____ SIGNATURE: _____

REV: 11/91

...DIATRIC CASE HISTORY

PREGNANCY HISTORY: ______________________

DELIVERY / BIRTH HISTORY: ______________________

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:

______ RESPOND TO SOUND
______ FOLLOW AN OBJECT WITH HIS/HER EYES
______ HOLD HEAD UP
______ SIT ALONE
______ CRAWL
______ STAND
______ WALK ALONE

CHILDHOOD DISEASES:

______ CHICKENPOX
______ MUMPS
______ MEASLES
______ RUBELLA
______ RUBEOLA
______ WHOOPING COUGH

OTHER: ______________________

HAS THIS CHILD EVER SUFFERED FROM:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive Disorders
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking Problems
- ☐ Arm Problems
- ☐ Blood Disorders
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Orthopedic Problems
- ☐ Sugar Concentration
- ☐ Paralysis
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Stomach Aches
- ☐ Chronic Earaches
- ☐ Colds/Flu
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Behavioral Problems
- ☐ Muscle Jerking
- ☐ Ruptures / Hernias
- ☐ "Growing Pains"
- ☐ Other

PRESENT HISTORY: ______________________

SURGERY: ______________________

MEDICATIONS: ______________________

ACCIDENTS: ______________________

FAMILY HISTORY: ______________________