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Pediatric Initial Health Assessment And Patient Information

Child's Name: ______________________________ **Date of Birth:** _________________________

Sex: Male or Female

Mailing Address: ____

Father's Name: ____

Social Security #: ___________________________ **Date of Birth:** _________________________

Employer: ________________________________ **Insurance Name:** ______________________

Mother's Name: ____

Social Security #: ___________________________ **Date of Birth:** _________________________

Employer: ________________________________ **Insurance Name:** ______________________

Emergency Contract: ________________________ **Phone:** _____________________________

Birth History

State, Country where child was born: ____

Birth weight: _____________________ Length: ___________________ Type of Delivery: ______________________

Pregnancy/ Delivery Problems? ____

Was baby discharged with mother? _____________________ Length of baby's hospital stay? _________________

Immunizations

Immunization Record Obtained? ________________________ Immunizations Current? ______________________

Medical History

Allergies to food and medications: ____

Accidents/ Illness: ____

Significant Illness: ______________________________ Hospitalization: ___________________________

Present Medication

___________________________________ _____________________________________

__________________________________ _____________________________________

__________________________________ _____________________________________

Insurance

Name of Insurance: _____________________________ ID#: _________________________________

Subscriber: ____________________________ Subscriber's Date of Birth: ________________________

Social History

Languages spoken at home: ____

Primary caretake of child: ____

Number of family members living in same house: ____

Name of School: ______________________________ Grade in School: ________________________

Siblings:

1. ____ Age: ____________
2. ____ Age: ____________
3. ____ Age: ____________
4. ____ Age: ____________

Lab Tests Done:

Blood Leads Test: _______________________ Urinalysis: ________________________________

Blood HGB/ HCT: _______________________ Sickle Cell Test: _____________________________

PKU Test: _____________________________

Environmental History

Exposure to tobacco smoke: YES OR NO

Drug use (age appropriate): YES OR NO

Alcohol use (age appropriate): YES OR NO

Tabaco use (age appropriate): YES OR NO

Child has had (CIRCLE ALL THAT APPLY)

- Chickenpox
- Mumps
- TB
- Measles
- Hearing problems
- Vision Problems

* Weight problems
* Seizures
*Headaches
* Pneumonia
* Bladder infections
*Sickle Cell Disease/ Trait

Any other problems: ____

Signature: ____ **Date:** _____________________________