Pediatric History Form

PARENT TO COMPLETE:

Current E-Mail Address:_____
Patient's Name: _____ DOB: _____ Date First Seen: _____
RACE: White_____ Black_____ Hispanic_____ Oriental_____ Other____ Sex: male_____ female_____
Mother's Full Name:_____ Father's Full Name:_____
Mother's Maiden Name: _____
Occupation_____ Occupation_____
Work Phone_____ Work Phone_____
Family Status: Single Parent___ Married to each other___ Separated/Divorced____ Year_____Remarried_____
Patient lives with: Name Relation Year Born

_____
_____
_____

Legal Guardian (if other than parent):_____
Relationship to child:_____

Past Medical History
Birth History: Weight at Birth_____ Full Term_____ Premature _____ Number of Weeks_____
Delivery: Vaginal ____ Caesarean_____ Reason for C/S: CPD _____ Breech _____ Fetal Distress_____ Other_____
Mother's Age at Birth of this child:_____ OB/GYN_____ Hospital_____
Maternal Health during Pregnancy: Prenatal Care_____ Starting? _____ Diabetes High BP Other
Perinatal Problems:_____
_____

Childhood Illnesses: Chicken Pox_____ Scarlet Fever_____ Measles_____ Other
Hospitalizations: _____
_____
Surgeries:_____

Allergies:_____
Adverse Reactions to shots, foods?_____
Family History:
Respiratory problems (RAD, asthma, emphysema) _____ Allergies: Hay Fever_____
Diabetes_____ High Blood Pressure_____ Heart Disease_____
Blood Problems (anemia, free bleeder)_____ Migraines Seizures_____
Alcohol or Drug Problems_____ Depression/Mental Problems_____
Kidney Problems (infections, stones)_____
Environmental/Social History:
Places Lived other than NC _____ Travel_____
Smokers_____ Location: Inside_____ Outside_____ Pets_____
Water Source: Well_____ City_____ County_____ Bottled_____
Problem List:_____
_____
_____

Piedmont HealthCare
Mooresville Pediatric & Adolescent Care

Agreement/Consent for Immunizations

I have been given a copy of, and have read or had explained to me, information about each of the diseases and the vaccines that are to be given to this child. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and the risks of each vaccine and request that they be given to the minor child for whom I am authorized to make this request.

This one signature will be assumed to be consent to all recommended vaccines unless specifically noted in the record.

Child's Name: _____

Parent/Guardian's Name: _____

Date: _____

PIEDMONT HEALTHCARE
PO BOX 1845
STATESVILLE, NC 28687

PRIVACY AND SAFETY NOTICE/AUTHORIZATION

Child's Name:_____ **DOB:**_____
Parent's Name(s): _____
_____
Legal Guardian, if not the parent: _____

In order for us to be in compliance with the new HIPPAA privacy laws, we must know who is authorized to bring this child to the office for treatment. We must also know who we are authorized to release information in written or verbal form, you may change these designations at any time. You may also send a note with the child if needed giving us permission to treat release information.

We can no longer fax medical information or leave information on an answering machine. We apologize for an inconvenience this may cause.

The following people can bring my child to the office for treatment:

Please list the person's names and relationship to the child:

_____
_____
_____
_____

You have permission to release written or verbal medical information about this child to:

Please list the person's names and relationship to the child:

_____
_____
_____
_____

Signature of parent:_____Date:_____