PEDIATRIC PATIENT HISTORY

Today's date _____

Child's name _____ Birthdate _____ Sex: male female

Mother _____ Birthdate _____

Address _____ Phone _____

Father _____ Birthdate _____

Address _____ Phone _____

Legal guardian (if other than parent) _____ Phone _____

Address _____

Siblings (names and birthdates)

_____

_____

Parents are: married ____ single ____ separated ____ divorced ____

Members of household _____

_____

Pets in the home _____ Smokers in the home _____

How old is home? _____ Water fluoridated? yes ____ no ____

Diet _____

Does child attend daycare or afterschool program? _____

Does your child attend church or community program? _____

Comments _____

ALLERGIES (please list) _____

BIRTH HISTORY

Length of pregnancy _____ Type of delivery: vaginal _____ C-section _____

Weight _____ Length _____ Apgar scores _____ / _____

Type of feeding: breast _____ formula (name) _____

Complications during pregnancy, labor or delivery _____

Problems in nursery _____

DEVELOPMENT At what age did the child first:

Roll over _____ Sit alone _____ Speak single words _____

Crawl _____ Walk alone _____ Make sentences _____

Toilet train _____

Did the child have any of the following problems during the first few months of life? (circle if yes)

jaundice	anemia	breathing difficulty
trouble feeding	seizures	blue spells
severe colic	infections	required oxygen

CHILDHOOD ILLNESSES Has the child had any of the following? (circle if yes)

chicken pox	meningitis	tubes in ears	pneumonia
asthma/wheezing	seizure	heart murmur	frequent ear infections

Other chronic or ongoing medical problems _____

_____

– Please complete both sides –

HOSPITALIZATIONS (for surgery, accidents or injuries). List date and reason for hospitalization

_____

_____

MEDICATIONS List all including vitamins, fluoride, iron, prescription and non prescription drugs.

_____

_____

_____

FAMILY HISTORY Do any of the child's close relatives (parents, grandparents, brothers or sisters) have any of the following? (circle if yes)

High blood pressure	Diabetes	Allergic disease	Seizures
Heart disease	Bleeding disorders	Asthma	Kidney disease
Sickle cell	Cystic fibrosis	Alcoholism	High cholesterol
Cancer	Mental problems		

IMMUNIZATIONS **Please provide us with a current list of all immunizations received.**

DOES THE CHILD HAVE ANY UNUSUAL PROBLEM WITH (circle if yes)

behavior	temper tantrums	nightmares	trouble in school
discipline	vision	bedwetting	learning difficulty
breathholding	speech	toilet training	attention deficit
hyperactivity	thumbsucking	snores	difficulty sleeping

WHAT RECENT PROBLEMS HAS THE CHILD HAD? _____

_____

_____

WHAT CONCERNS DO YOU HAVE TODAY?

_____

_____

_____

_____

_____

Carolinas HealthCare System

HIPAA* Authorization Form

Patient Name: _____ DOB: _____

Do you agree to share information (lab results, medication requests, appointments, billing information, etc.) with anyone?

☐ No, I do not wish to share any information

☐ Yes (please fill in additional information)

Contact Name	Contact Number	Relationship	Comments

Signature: _____ Date: _____

Printed Name (if other than the patient): _____

Relationship: _____

** Health Insurance Portability and Accountability Act of 1996*