Original Date:	
Dates Revised:	12/09/2014

PEDIATRIC REGISTRATION QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	**SSN:**
Mailing Address:	Street:	Apt:		
	City: State:	Zip:		
Parent Home Phone:				
Parent Work Phone:				
Parent Cell Phone:				

Guarantor Information (Responsible Party)	
Name *(Last, First, M.I.):*	**DOB:** **SSN:**
OTHER RESPONSIBLE PARTIES	
Name *(Last, First, M.I.):*	**Relationship to patient:**
Name *(Last, First, M.I.):*	**Relationship to patient:**
Name *(Last, First, M.I.):*	**Relationship to patient:**
Name *(Last, First, M.I.):*	**Relationship to patient:**
EMERGENCY CONTACT	
Name *(Last, First, M.I.):*	**Relationship to patient:**
Phone:	

PAST MEDICAL HISTORY

(check all that apply)		
	☐ ADHD/ADD	☐ Learning Problem
	☐ Anxiety	☐ Depression
	☐ Seizures	☐ Genetic Problem
	☐ Crohn's	☐ Ulcerative Colitis
	☐ Eczema	☐ Celiac Disease
	☐ Migraines	☐ Heart Defects
	☐ Asthma	☐ Wheezing
	☐ Diabetes	☐ UTI
	☐ Other	☐ Other

Surgeries

Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital
Are your immunizations up to date (current)? Please bring records.		☐ **Yes** ☐ **No**

List the primary pharmacies you used over the last two years (24 months): (*Use back page if more than two were used***)**			
Pharmacy 1: name:		Phone number	( )
Street address:	City:	State:	ZIP Code:
Dates from:	To:		
Pharmacy 2: name:		Phone number	( )
Street address:	City:	State:	ZIP Code:
Dates from:	To:		

List your prescribed drugs and over-the-counter drugs, such as vitamins, herbs and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction Your Child Had	

LEAD AND TB RISK ASSESSMENT

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.	
	☐ Child has a history of lead exposure
	☐ Home built before 1970
	☐ Home has chipping or peeling paint

	☐ Parent's occupation involves lead exposure (i.e. battery recycling plant, radiator repair, etc.)
	☐ Child eats clay, paint chips, etc.
	☐ Child has ingested folk remedies (i.e. Azarcon, Greta, Ghasard, Ba-Baw-San)
	☐ Child has immediate family members, playmates, or neighbors with a history of lead exposure
	☐ Family is currently homeless or living in a shelter
	☐ Child has TB, HIV, AIDS
	☐ Child immigrated from a country endemic to TB i.e. India, South East Asia, Central or South America, Haiti, Russia, etc.

SOCIAL HISTORY

Is your child in daycare?	☐ Yes	☐ No
School Problems? If yes, explain.	☐ Yes	☐ No
Are there any firearms/guns in the home?	☐ Yes	☐ No
Are there pets in the home?	☐ Yes	☐ No
Is your child exposed to any tobacco products at home?	☐ Yes	☐ No
Who has custody of the child?		
Who lives in the home with the child?		

FAMILY HEALTH HISTORY

Do any family members have any of the following conditions?

	Mother	*Father*	*Sibling*	*Maternal Grandfather*	*Maternal Grandmother*	*Paternal Grandfather*	*Paternal Grandmother*
ADHD/ADD	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Learning disorder	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐

Other? Please Describe

Disclosure:
Please provide the most current and complete information in this history questionnaire. This information is used solely by the physician and staff for the purpose of determining your medical needs and services. The information will assist in assessing if any exceptional or specialized services may be required, and how it can be best delivered to each unique patient and her medical needs.