



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 <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	SSN:
Mailing Address: Street:		Apt:		
City:		State: Zip:		
Parent Home Phone:				
Parent Work Phone:				
Parent Cell Phone:				
Guarantor Information (Responsible Party)				
Name <i>(Last, First, M.I.):</i>		DOB:		SSN:
OTHER RESPONSIBLE PARTIES				
Name <i>(Last, First, M.I.):</i>		Relationship to patient:		
Name <i>(Last, First, M.I.):</i>		Relationship to patient:		
Name <i>(Last, First, M.I.):</i>		Relationship to patient:		
Name <i>(Last, First, M.I.):</i>		Relationship to patient:		
EMERGENCY CONTACT				
Name <i>(Last, First, M.I.):</i>		Relationship to patient:		
Phone:				

PAST MEDICAL HISTORY

<i>(check all that apply)</i>	<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Learning Problem
	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Genetic Problem
	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis
	<input type="checkbox"/> Eczema	<input type="checkbox"/> Celiac Disease
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Heart Defects
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Wheezing
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> UTI
	<input type="checkbox"/> Other	<input type="checkbox"/> 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

<input type="checkbox"/>	Parent's occupation involves lead exposure (i.e. battery recycling plant, radiator repair, etc.)
<input type="checkbox"/>	Child eats clay, paint chips, etc.
<input type="checkbox"/>	Child has ingested folk remedies (i.e. Azarcon, Greta, Ghasard, Ba-Baw-San)
<input type="checkbox"/>	Child has immediate family members, playmates, or neighbors with a history of lead exposure
<input type="checkbox"/>	Family is currently homeless or living in a shelter
<input type="checkbox"/>	Child has TB, HIV, AIDS
<input type="checkbox"/>	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
School Problems? If yes, explain.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any firearms/guns in the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there pets in the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child exposed to any tobacco products at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?

	<i>Mother</i>	<i>Father</i>	<i>Sibling</i>	<i>Maternal Grandfather</i>	<i>Maternal Grandmother</i>	<i>Paternal Grandfather</i>	<i>Paternal Grandmother</i>
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug/alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged QT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.