

(please read & complete front & back)



Northeast Health Center (NHC)
Teen Health Center at Parkside (TCAP)
Jackson High Health Center (JHHC)
Northwest Community Health Center (NWCHC)
Pediatric Patient History

Student Name:
Last:
First:
Birth Date:
Age:

Male Female Address: City: Zip code: Telephone #'s: Home: Other:

Grade: School: Primary Language Spoken: By patient In home

Parent/Guardian
(1) Last Name First Name Birth date:
Relationship to Student Daytime telephone Work telephone
Cell/Pager
(2) Last Name First Name Birth date:
Relationship to Student Daytime telephone Work telephone
Cell/Pager

Name of Emergency Contact (other than parent): Relationship: Telephone #:

Name of Student's Physician: Name of Student's Dentist: Date of last dental visit:

Insurance - Medical Policy #:

Insurance - Dental Policy #:

Subscriber: Birth Date: Relationship to Student:

INFORMATION NEED FOR FEDERAL FUNDING (this information is not used on an individual basis)

Income \$ Annual Monthly Weekly
Race: White Black Pacific Islander Asian American Indian More than 1 Unknown
Ethnicity: Hispanic Not Hispanic Unknown
Total Number Living in Household?
Census: Patient lives in City of Jackson Patient lives in County of Jackson Patient lives outside County of Jackson

Name of Medication:	Dose:	How Often:
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Preferred Pharmacy:

Please list all allergies:

PREGNANCY AND BIRTH HISTORY

Mother's age at birth _____ **Did mother receive prenatal care?** Yes No

Any problems/illness during pregnancy?	<input type="checkbox"/> Diabetes during pregnancy	<input type="checkbox"/> Sickle Cell Trait
	<input type="checkbox"/> Diabetes before pregnancy Insulin Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Heart Disease
	<input type="checkbox"/> High blood pressure during pregnancy	<input type="checkbox"/> Kidney Disease
	<input type="checkbox"/> High blood pressure before pregnancy	<input type="checkbox"/> Infection during pregnancy (if yes, type of infection)
	<input type="checkbox"/> Surgery during pregnancy (if yes, type of surgery)	
	<input type="checkbox"/> Other: _____	

Use during pregnancy?	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Marijuana
	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Other Drug Use: _____

Type of delivery	<input type="checkbox"/> Vaginal delivery	<input type="checkbox"/> Cesarean section emergency	<input type="checkbox"/> Cesarean section - Elective
	<input type="checkbox"/> Forceps	<input type="checkbox"/> Vacuum assisted	

Did baby come on time? Weeks at delivery: _____ (40 weeks-full term)

Birth Weight / Length? **Birth Weight** _____ **pounds** _____ **ounces** **Birth Length** _____ **inches**

Any problems with delivery or with baby at birth?	<input type="checkbox"/> Oxygen needed
	<input type="checkbox"/> Evaluated for Infection
	<input type="checkbox"/> Jaundice <input type="checkbox"/> Phototherapy
	<input type="checkbox"/> Admitted to special care nursery or neonatal intensive care (if checked, please give reason) # of days in nursery _____

PAST MEDICAL HISTORY – Please mark any that apply to your child

<p><i>Cardiac</i></p> <input type="checkbox"/> Heart murmur <input type="checkbox"/> High blood pressure <input type="checkbox"/> Rheumatic fever Other: _____	<p><i>Respiratory</i></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Breathing treatments Machine at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep Apnea Other: _____	<p><i>Genitourinary</i></p> <input type="checkbox"/> Bed wetting <input type="checkbox"/> Frequent urination <input type="checkbox"/> Frequent urine infections <input type="checkbox"/> Kidney or bladder problems Other: _____
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<p>Neuropsych</p> <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Anxiety <input type="checkbox"/> Cutting behavior <input type="checkbox"/> Depression <input type="checkbox"/> Eating disorder <input type="checkbox"/> Seizures Other: _____	<p>HEENT</p> <input type="checkbox"/> Frequent ear infections Tubes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Headaches <input type="checkbox"/> Hearing problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Vision problems Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____	<p>Musculoskeletal</p> <input type="checkbox"/> Broken bone part of body? _____ <input type="checkbox"/> Flat feet <input type="checkbox"/> Pain in joints Other: _____															
<p>Hematologic/Neoplastic</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Sickle cell disease Other: _____	<p>Dermatologic</p> <input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Hives/Rash <input type="checkbox"/> Warts Other: _____	<p>Immunologic</p> <input type="checkbox"/> Bee sting allergies <input type="checkbox"/> Food allergies Type: _____ <input type="checkbox"/> Hay fever <input type="checkbox"/> Latex allergy <input type="checkbox"/> Medication allergy (see allergies on page 2) <input type="checkbox"/> Pet allergies Other: _____															
<p>Infectious Disease</p> <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HIV <input type="checkbox"/> MRSA <input type="checkbox"/> RSV Other: _____	<p>Gastrointestinal</p> <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Stomach pain Other: _____	<p>Metabolic</p> <input type="checkbox"/> Diabetes Other: _____															
<p>Overnight Hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please explain)</p>																	
<p>Surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please list surgeries and dates)</p>																	
SOCIAL HISTORY																	
<p>Child Lives With:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Mother</td> <td><input type="checkbox"/> Sisters</td> <td>Other _____</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Brothers</td> <td>Other _____</td> </tr> <tr> <td><input type="checkbox"/> Step Father</td> <td>Other _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Step Mother</td> <td>Other _____</td> <td></td> </tr> </table>			<input type="checkbox"/> Mother	<input type="checkbox"/> Sisters	Other _____	<input type="checkbox"/> Father	<input type="checkbox"/> Brothers	Other _____	<input type="checkbox"/> Step Father	Other _____		<input type="checkbox"/> Step Mother	Other _____				
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<input type="checkbox"/> Step Mother	Other _____																
<p>Is the child in daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	
<p>Smoking in the house? <input type="checkbox"/> Yes <input type="checkbox"/> No Outside only? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	
<p>Water source: <input type="checkbox"/> Well water <input type="checkbox"/> City water</p>																	
<p>Lead in home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																	
<p>Smoke detectors in home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	
<p>Pets in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____</p>																	
<p>Name of school attending: _____ Grade: _____</p>		<p>Learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>															
<p>Any sleep problems/Nightmares? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	
<table style="width:100%;"> <tr> <td>Siblings</td> <td>Gender</td> <td>Date of Birth: _____</td> </tr> <tr> <td>Name: _____</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td>Date of Birth: _____</td> </tr> <tr> <td>Name: _____</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td>Date of Birth: _____</td> </tr> <tr> <td>Name: _____</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td>Date of Birth: _____</td> </tr> <tr> <td>Name: _____</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td>Date of Birth: _____</td> </tr> </table>			Siblings	Gender	Date of Birth: _____	Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____	Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____	Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____	Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____
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FAMILY HISTORY

Mother's date of birth _____

Family History Unknown - Patient adopted

Father's date of birth _____

Please mark any that apply to child's family members

Diagnosis	Patient's Father	Patient's Mother	Patient's Sister	Patient's Brother	Other Relative
Anxiety					
Asthma					
Alcoholism					
Blood Disease					
Heart disease					
Cancer					
Depression					
Diabetes					
Hearing loss					
High cholesterol					
High blood pressure					
Learning disability					
Mental Illness					
Migraines					
Obesity					
Renal disease/kidney problems					
Seizure disorder					
Sickle cell disease					
Stroke					
Substance abuse					
Thyroid disease					
Tuberculosis					
Other					
Other					
Other					

Family members deceased

- Patient's Father
- Patient's Mother
- Patient's Sister
- Patient's Brother

Cause of death:

- Father _____
- Mother _____
- Sister _____
- Brother _____

Age at death:

- Father _____
- Mother _____
- Sister _____
- Brother _____

Provider Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____