IHA

Pediatrics

Seen by:_____ Reviewed by:_____

Patient Name: _____ **M/F** **Date of Birth:** _____

Parent Names: _____ **Siblings & DOB:** _____

Significant Past Medical Problems, illnesses or hospitalizations:_____

_____

_____

_____

Has your child had chicken pox disease: ☐ Yes Date: _____ ☐ No

Has your child had any of the following operations? If yes, fill in the year of surgery.

	Year
Appendix Removed	
Tonsils/Adenoids Removed	
Ear Tubes	

Other operations/procedures: _____

_____

Active or Chronic Problems (check all that apply for this patient or list below):

☐ ADD/ADHD	☐ DDH – hip dysplasia	☐ Diabetes	☐ High blood pressure	☐ Seizures
☐ Allergies	☐ Deafness	☐ Ear Infections (frequent)	☐ Mental illness	☐ Strabismus (lazy eye)
☐ Asthma	☐ Depression/Anxiety	☐ Eczema	☐ Migraines/Headaches	☐ Sickle Cell
☐ Cancer	☐ Developmental Delay	☐ Elevated Cholesterol	☐ Obesity	☐ Urinary Reflux
☐ Other (list below)		☐ Heart Disease	☐ Scoliosis	☐ Frequent or Recurrent UTI

Please explain any that apply:

_____

Please list other active or chronic problems: _____

_____

Please list other pertinent information we should know, including other doctors and/or specialists your child sees:

_____

_____

Patient's Drug Allergies & reaction: _____

Patient's Food Allergies & reaction: _____

Current Medications – Please list all over the counter medications, supplements, herbal medications and/or any medications prescribed by your PCP or specialist.

Medication	Dosage	Times per Day	Prescribed by

Patient Name: _____ Date of Birth: _____

CHECK A BOX THAT APPLIES FOR EACH CATEGORY BELOW

Social History

Mother's Occupation: _____ ☐ Full Time ☐ Part time ☐ School

Father's Occupation: _____ ☐ Full Time ☐ Part time ☐ School

Parent's Relationship: ☐ Married ☐ Living Together ☐ Single Parent ☐ Guardian ☐ Foster Parent ☐ Same Sex Parents ☐ Separated ☐ Never together ☐ Divorced ☐ Father in Jail ☐ Mother in Jail

Child Care: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling ☐ Nanny ☐ Daycare ☐ Sitter ☐ N/A ☐ Other: _____

Safety: Special Needs:

☐ None Known
☐ ADD/ADHD
☐ Behavior Problems
☐ Excessive Absences
☐ Failing
☐ IEP in place
☐ IEP pending
☐ Legal
☐ Math
☐ Math/Reading
☐ Physical disability
☐ Reading
☐ Special Needs Classroom
☐ Speech
☐ SPED/LD
☐ Title 1
☐ Other: _____
☐ Other: _____

Learning Disabled:

☐ None Known
☐ Articulation disorder
☐ Dyscalculia (Numbers)
☐ Dyslexia
☐ Expressive language disorder
☐ Motor skills disorder
☐ Receptive language disorder
☐ Writing disorder

Home Safety:

(Please check a box for each category)

Smokers in home
☐ Yes ☐ No

Carbon monoxide detector
☐ Yes ☐ No

Smoke detector
☐ Yes ☐ No

Uses bike/skating helmet
☐ Yes ☐ No

Firearms in home
☐ Yes ☐ No

Radon in home
☐ Yes ☐ No
☐ Untested
☐ Untreated
☐ Treated

Seatbelt/car restraint
☐ Face rear
☐ Booster
☐ Face front
☐ Seatbelt

Pets/animals in home
☐ Birds
☐ Cats
☐ Dogs
☐ Ferrets
☐ Guinea pigs
☐ Hamsters
☐ Mice
☐ Rabbits
☐ None

Lead exposure
☐ Lead in home
☐ No lead in home
☐ Lead removed
☐ Lead status unknown

Water
☐ City
☐ Well
☐ Water fluoridated

Family History: ☐ **N/A or answer below** ☐ Patient Adopted

	Mother	Father	Brother	Brother	Sister	Sister	Mom's mother	Mom's father	Dad's mother	Dad's father
Deceased (age?, include reason)										
ADD/ADHD										
Allergies										
Asthma										
Cancer (type?)										
DDH – hip dysplasia										
Deafness										
Depression										
Developmental delay										
Diabetes										
Elevated Cholesterol										
Eczema										
Heart Disease										
High blood pressure										
Learning disability										
Mental illness										
Migraines										
Obesity										
Scoliosis										
Seizures										
Sickle Cell										
Strabismus (lazy eye)										
Sudden death < 55										
Other:										