Holy Cross Pediatrics

First Visit Patient Information and History

Today's Date: _____

Reason for Visit: _____

Child's Name: _____
Age: _____ **Date of Birth:** _____
Prior Pediatrician: _____
Date of Last Physical/Check-up: _____
Does your child see any other doctors or specialists: ☐YES ☐NO
If yes, for what reason or diagnosis:
_____

Parent #1's Name: _____
Best contact phone #(_____)_____Occupation: _____
Physical Address:_____
Email: _____

Parent #2's Name: _____
Best contact phone #(_____)_____Occupation: _____
Physical Address:_____
Email: _____

Primary Pharmacy: _____
_____

Please list any persons (other than parents) who may accompany your child to their appointments, may consent for treatment, and whom we may inform about your child's condition, diagnosis and treatment.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please list the name(s) of persons who are *NOT* allowed to consent for treatment or be informed about your child's medical condition or diagnosis. If it is a child's parent, please provide us with a copy of legal documents regarding custody or specific restrictions.

Name: _____ Relationship: _____

Emergency Contact if parents cannot be reached:
Name: _____
Relationship:_____
Best contact phone#(_____)_____
Address:_____

BIRTH HISTORY

Please list the hospital where your child was born:_____
Birth weight: _____
Was the birth: ☐VAGINAL ☐CESAREAN
If Cesarean, why?_____
Was your baby born at 38 weeks or more? ☐YES ☐NO
If not, how many weeks gestation? _____
Did your baby have any problems right after birth? ☐YES ☐NO
If yes, details:

_____
Was your baby ever in the neonatal ICU? ☐YES ☐NO
If yes, details: _____
Did mother have any illness or problems with her pregnancy? ☐YES ☐NO
If yes, details:

_____
Did mother take prenatal vitamins during pregnancy? ☐YES ☐NO
Did mother take any other medications during pregnancy? ☐YES ☐NO
If yes, what medications?_____
During pregnancy, did mother:
Smoke cigarettes: ☐YES ☐NO
Use E-cigarettes/vape: ☐YES ☐NO
Drink Alcohol: ☐YES ☐NO
Use Drugs: ☐YES ☐NO
If yes, what drugs: _____
Was initial feeding: ☐Breast Milk ☐Formula ☐Both
Did your child go home with mother from the hospital after birth? ☐ yes ☐ no

CURRENT AND PAST MEDICAL HISTORY

Do you consider your child to be in good health? ☐YES ☐NO
Is your child currently taking any prescription medications?☐YES ☐NO
If yes, details:

_____
Is your child currently taking any over the counter medications or supplements? ☐YES ☐NO
If yes, details:

_____
Is your child allergic to any medications or other substances? ☐ YES ☐ NO
If yes, details:

_____
Are your child's immunizations up to date? ☐YES ☐NO

Do you have your child's immunization records? ☐YES ☐NO

Has your child had any reactions to immunizations? ☐YES ☐NO
If yes, details:

Does your child have any serious or chronic illnesses? ☐YES ☐NO

If yes, details:

_____

Has your child had serious injuries or accidents? ☐YES ☐NO

If yes, details:

_____

Has your child had any surgery? ☐YES ☐NO

If yes, details:

_____

Has your child ever been hospitalized other than at birth? ☐YES ☐NO

If yes, details:

_____

Does your child have a dentist? ☐YES ☐NO

If yes, dentist's name:_____

DOES YOUR CHILD HAVE, OR HAVE THEY EVER HAD?

Problems diagnosed during infancy: ☐YES ☐NO

If yes, details:

_____

Asthma, wheezing, chronic cough or breathing problems: ☐YES ☐NO

If yes, details:_____

Does your child use an inhaler and/or nebulizer? ☐YES ☐NO

Pneumonia: ☐YES ☐NO

If yes, details:_____

Nasal allergies: ☐YES ☐NO

If yes, details:_____

Frequent ear infections or sore throats: ☐YES ☐NO

If yes, details: _____

Hearing loss or concerns: ☐YES ☐NO

If yes, details: _____

Eye problems, vision problems or concerns: ☐YES ☐NO

If yes, details: _____

Problems with teeth or multiple cavities: ☐YES ☐NO

If yes, details: _____

Heart problem or heart murmur: ☐YES ☐NO

If yes, details:_____

High blood pressure: ☐YES ☐NO

If yes, details: _____

Stomach problems or frequent abdominal pain: ☐YES ☐NO

If yes, details: _____

Constipation requiring medical treatment: ☐YES ☐NO

If yes, details:

_____

Urinary tract infections: ☐YES ☐NO

If yes, details:

_____

Kidney or bladder problems: ☐YES ☐NO
If yes, details:

_____

Frequent headaches: ☐YES ☐NO
If yes, details:

_____

Head injury or concussion: ☐YES ☐NO
If yes, details:

_____

Seizures or other neurologic problems: ☐YES ☐NO
If yes, details:

_____

Anemia or bleeding problems: ☐YES ☐NO
If yes, details:

_____

Bone, joint or muscle problems: ☐YES ☐NO
If yes, details:

_____

Serious injuries or accidents: ☐YES ☐NO
If yes, details:

_____

Skin problems, eczema or rashes: ☐YES ☐NO
If yes, details:

_____

Diabetes: ☐YES ☐NO
If yes, details:

_____

Thyroid or other endocrine problems: ☐YES ☐NO
If yes, details:

_____

Weight or growth problems: ☐YES ☐NO
If yes, details:

_____

Exposure to family violence: ☐YES ☐NO
If yes, details:

_____

Developmental or learning problems: ☐YES ☐NO
If yes, details:

_____

Has your child received Occupational Therapy, Physical Therapy or Speech Therapy: ☐YES☐NO
If yes, details:

_____

Any other medical problems:

Child under 2

Feeds: ☐Breast ☐Formula ☐Regular Milk

How long does he/she sleep at night without feeding?_____

If your child breast feeds, how often?_____

If your child drinks formula, how much per bottle? _____How often?_____

Drinking other liquids? ☐NONE ☐WATER ☐ JUICE ☐OTHER, specify:_____

Is your baby eating baby or table food? ☐YES ☐NO

If yes, describe: _____

Does your child have any feeding problems? ☐YES ☐NO

Age 2-4

What type of mild does your child drink? ☐WHOLE ☐1 or 2% ☐NONFAT ☐OTHER

How much milk per day? _____

What other liquids does your child drink, and how much per day?

Does your child have any feeding problems? ☐YES ☐NO

Potty trained? ☐YES ☐NO ANY DETAILS?_____

Ages 5 and up

ADHD: ☐YES ☐NO

Do you have concerns about mental health issues (anxiety, depression)? ☐YES ☐NO

How much milk does your child drink per day?_____

How much soda/juice/other sweet beverages does your child drink per day?_____

Do you have any concerns about your child's diet? ☐YES ☐NO

Ages 10 and up

Does your child drink alcohol, smoke and/or use drugs? ☐YES ☐NO

If yes, describe: _____

Female 11 and up

Has your child started her menstrual period? ☐YES ☐NO If yes, age of first period:_____

Any concerns about periods? ☐YES ☐NO

If yes, describe:_____

Last Menstrual Period: _____

Please tell us if you have any other issues or concerns not listed above:

_____

Social History/Household Information

Please list all those living in the child's home:

Name	Relationship to Child	Date of Birth

Are there siblings not listed? If so, please list their names, ages and where they live:

Name	Age	Where they Live

Does the child live with both biological parents in the same household? ☐YES ☐NO

If no, what is the child's living situation and who has legal custody of the child?

☐Single parent custody ☐Joint parental custody ☐Adoptive family ☐Foster care
☐In custody of other family members

Details:_____

If child does not live with one or both biological parents, does the child have visitation with the parent(s) they do not live with? ☐YES ☐NO

If yes, how often?_____

Does anyone in the household smoke cigarettes, marijuana, or vape? ☐YES ☐NO

If yes, who? _____

Are there pets in the household? ☐YES ☐NO

If yes, what pets?_____

Is your child in daycare or school? ☐YES ☐NO

If yes, what is the name of the daycare or school?_____

If in school, what grade?_____

Does your child have any school special education, special resource classes or accommodations or IEP? ☐YES ☐NO

If yes, details:

For children not in daycare or school, who cares for the child during the day? _____

_____

Family Medical History (Your Child's Blood Relatives: Siblings, Parents, Grandparents, Aunts, Uncles, Cousins)

Have any of these family members had the following: (if yes, who and give any details you know)

Problems Diagnosed at Birth ☐YES ☐NO Who: _____Details: _____
Anemia or bleeding problems☐YES ☐NO Who: _____Details: _____
Alcohol use problems ☐YES ☐NO Who: _____
Asthma or lung problems ☐YES ☐NO Who: _____Details: _____
Any kind of Allergies ☐YES ☐NO Who: _____To what: _____
Autism ☐YES ☐NO Who: _____
Cancer ☐YES ☐NO Who: _____What kind: _____
Hearing/ear problems ☐YES ☐NO Who: _____Details: _____
Dental decay or multiple cavities ☐YES ☐NO Who: _____
Depression ☐YES ☐NO Who: _____
Developmental/learning problem☐YES ☐NO Who: _____Details: _____
Diabetes ☐YES ☐NO Who: _____Type 1 or 2: _____
Drug abuse/addiction ☐YES ☐NO Who: _____Details: _____
Heart attack before age 55y ☐YES ☐NO Who: _____
High Blood Pressure ☐YES ☐NO Who: _____
High Cholesterol or Lipids ☐YES ☐NO Who: _____
HIV or AIDS ☐YES ☐NO Who: _____
Kidney disease ☐YES ☐NO Who: _____Details: _____
Liver disease ☐YES ☐NO Who: _____Details: _____
Other mental health conditions ☐YES ☐NO Who: _____Details: _____
Obesity ☐YES ☐NO Who: _____
Seizures or epilepsy ☐YES ☐NO Who:_____Type/age:_____
Skin problem ☐YES ☐NO Who: _____Details: _____
Stomach or digestive problems ☐YES ☐NO Who: _____Details: _____
Stroke ☐YES ☐NO Who: _____What age?_____
Sudden death before age 50y ☐YES ☐NO Who: _____Cause?_____
Thyroid or other endocrine disease☐YES ☐NO Who: _____Details: _____
Tuberculosis ☐YES ☐NO Who: _____
Vision or eye problems ☐YES ☐NO Who: _____Details: _____

Do you know of any other family medical history?

_____

_____

Do you have any other concerns not listed above?

Parent 1 and Guarantor (person responsible for bill):
Last Name: _____First Name: _____MI:__Date of Birth:_____
Social Security#:_____
Relationship with Child: _____
Mailing Address: _____ _____
City:_____ State:_____ Zip Code:_____
Home Phone: _____Cell Phone:_____
Physical Address (if different from above): _____
City: _____ State: _____ Zip Code:_____
Employer: _____ Work Phone: _____
Email Address:
_____

Parent 2:
Last Name: _____First Name: _____MI:__Date of Birth:_____
Social Security#:_____
Relationship with Child: _____
Mailing Address: _____ _____
City:_____ State:_____ Zip Code:_____
Home Phone: _____Cell Phone:_____
Physical Address (if different from above): _____
City: _____ State: _____ Zip Code:_____
Employer: _____ Work Phone: _____
Email Address:
_____

Please list all Insurance Information

Insurance Information (Primary):
Name of Insurance: _____
Insurance ID #: _____
Group # or Group Name: _____

Insurance Information (Secondary):
Name of Insurance: _____
Insurance ID #: _____
Group # or Group Name: _____