Twin City Pediatrics Demographic

Date:__________________

Oldest Child's Name:__________________________________Birth date:_____________________Gender:__________

Child #2 Name:_______________________________________Birth date:_____________________Gender:__________

Child #3 Name:_______________________________________Birth date:_____________________Gender:__________

Child #4 Name:____Birth date:____________________Gender:_________

Child #5 Name:____Birth date:____________________Gender:_________

Parent /Guardian 1: ____________________________________Birth date:____________SS#_______________________

Address:____Phone (H)_____________________(C)_________________

City/Sate/Zip Code:____

Employer:____Occupation: ______________________________________

Work Phone:_______________________________________Email Address: _____________________________________

Parent /Guardian 2: ____________________________________Birth date:______________SS#_________________________

Address:____Phone (H)_____________________(C)_________________

City/Sate/Zip Code:____

Employer:____Occupation: ______________________________________

Work Phone:_______________________________________Email Address: _____________________________________

Who referred you to this practice?____

Which parent is the primary insurance carrier responsible for bills from this office? ___________________________

Emergency contact name (other than parent)___________________________Phone: _________________________

Please list names of any people that may bring your child to our office and that you give permission to make medical decisions on your behalf:

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NOVANT HEALTH

New Patient Medical History

Patient Name:___________________________

DOB:_______________

Medications/Allergies:

Is your child on any daily medications?________If so please list medications____

____

Does your child have any allergies to medicines?_______Please list:______________________________Foods?__________________

Other allergies?____

Past Medical History: Does/did your child have:

Y	N	
☐	☐	1. Complications during pregnancy/labor/ delivery____________________________
☐	☐	2. Complications in newborn nursery _________ ___________________________________
☐	☐	3. Prematurity
☐	☐	4. Asthma/wheezing
☐	☐	5. Chicken Pox
☐	☐	6. Eczema/Hives
☐	☐	7. Developmental or Speech Delay
☐	☐	8. ADHD/attention problems?
☐	☐	9. Major Infections________________________
☐	☐	10. Other chronic health problems _____________ _______________________________________
☐	☐	11. Previous surgeries (what and when) _______________________________________
☐	☐	12. Hospitalizations (for what and when) _______________________________________

Family History: Please check if the child's parents, grandparents, aunts, uncles, or siblings have had; if answer yes list family member who had illness:

Y	N		
☐	☐	1. Alcohol Abuse	Relationship to child___________________________
☐	☐	2. Allergy	Relationship to child___________________________
☐	☐	3. Asthma	Relationship to child___________________________
☐	☐	4. Birth Defects	Relationship to child___________________________
☐	☐	5. Childhood Cancer	Relationship to child___________________________
☐	☐	6. Diabetes	Relationship to child___________________________
☐	☐	7. Drug Abuse	Relationship to child___________________________
☐	☐	8. Early Death	Relationship to child___________________________
☐	☐	9. Hearing Loss	Relationship to child___________________________
☐	☐	10. Heart Attack before age 50 yrs	Relationship to child___________________________
☐	☐	11. High Cholesterol	Relationship to child___________________________
☐	☐	12. High Blood Pressure	Relationship to child___________________________
☐	☐	13. Kidney Disease	Relationship to child___________________________
☐	☐	14. Learning Disability	Relationship to child___________________________
☐	☐	15. Mental Retardation	Relationship to child___________________________
☐	☐	16. Mental Illness	Relationship to child___________________________
☐	☐	17. Seizures	Relationship to child___________________________

Social History:

Who lives in the house with your child?____

Does anyone at home smoke?____

What is the water source for the home (circle) City/County Well

Who cares for your child during the day?____

If your child attends school:

What school and grade level?____

What grades or marks does your child receive?____

Does your child get along well with other children?____

Circle if you have concerns about any of the following: Bed wetting, Thumb sucking, Nightmares, Temper Tantrums, Breath Holding, Discipline, or Toilet Training. Any other concerns?____