LYNCHBURG Pediatrics

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PEDIATRIC PATIENT HISTORY FORM

Chart#_____

Patient Name: _____Nickname:_____ Date of Birth: _____

Transferred or moved from: _____

Parent/Guardian #1 Name: _____ Height: _____

Parent/Guardian #2 Name: _____ Height: _____

Parents: Married Divorced Separated Single Who does the child live with? _____

Siblings - please list:
NAME: _____DOB_____ NAME:_____DOB:_____

NAME: _____DOB_____ NAME:_____DOB_____

PATIENT'S MEDICAL HISTORY Please circle each question and describe if YES. Has or does your child have or seen:

Allergies	**No**	**Yes**	_____
Hospitalizations	**No**	**Yes**	_____
Surgeries	**No**	**Yes**	_____
Specialist care	**No**	**Yes**	_____
Psychiatrist	**No**	**Yes**	_____
Emergency room	**No**	**Yes**	_____
Dentist	**No**	**Yes**	_____
Counseling	**No**	**Yes**	_____

Any medical issues we should be aware of or concerns? _____
Any medications taken regularly (over the counter, prescription, supplements, vitamins)? Include doses and frequency.
_____
_____
When was your child last seen by a Doctor? _____Where? _____

Any developmental concerns or learning problems? **No Yes**_____
Any behavioral problems? **No Yes** _____
Does your child have close friends? **No Yes** Are you worried about your child's social skills? **No Yes**
Does your child go to the dentist yearly? **No Yes** Do you like your dentist? **No Yes, name** _____
Where does your child go to school/preschool?_____ Grade?_____ Reading level?_____
Is your child getting the help they need to learn? **No Yes** Do they have an IEP? **No Yes** _____
Can your child swim? **No Yes** Have they had swimming lessons? **No Yes**

Do you read to your child? **No Yes** nightly? **No Yes** How happy are you with how **you** read? 

HOME Please answer by circling and explaining below
Do you live in an apartment, mobile home, town home or house
Who lives in your home?_____
Does your house have well water? **No Yes**
Are there guns in your home? **No Yes** Are they locked away ? **No Yes**
Do you ever have trouble paying your electricity/heat/phone bill? **No Yes**
Have you worried about having enough food to get through the week? **No Yes**
Do you receive WIC? **No Yes** Food Stamps? **No Yes**
Do you feel safe in your neighborhood? **No Yes**
Do you (or anyone else in your home) ever feel afraid of someone else who lives in the home? **No Yes**

COMMUNICATION NEEDS:
Language spoken at home if other than English: Child _____ Parent(s) _____
Any special communication needs? **No** **Yes** _____

PATIENT RIGHTS:
Is there anything we need to know about your religion or culture in order to care for your child? **NO** **YES**
_____

FAMILY MEDICAL HISTORY- please mark with X below

Medical condition										
	Does your child have	Mother	Father	Sister	Brother	Mom's mother	Mom's Father	Dad's Mother	Dad's Father	Other
Allergies										
Anemia										
Asthma										
Bleeding Disorder										
Cancer										
Heart Attack/Heart disease										
Sudden death										
Diabetes										
Eczema										
Epilepsy/Seizures										
Hearing loss/Deafness										
High Cholesterol										
High Blood Pressure										
Kidney Disease										
Thyroid Disease										
ADHD										
Depression/ mental illness										
Learning disorder/dyslexia										
Suicide										
Alcohol/drug use										
OTHER/										

We are thankful and appreciative you have chosen our office for your child's care. Please let us know if you have any specific concerns or needs. We are here to serve your family, the more we know about your family the more we can cater your visits and care to you and your child's needs.
Please ask for resources in our area for any of your needs. Medical and local resources are listed on our website www.//lynchburgpediatrics.com

NOTES:
_____
_____
_____