SPRINGVILLE PEDIATRICS

Annual Health Review

Patient Information

Confidential

Dear Parent,
Please take a moment to complete the attached review of your child's health. Whether your child is a new patient or a long time existing patient, it is always a good idea to review and make sure that your child's doctor has the most current information about your child's health, including past medical, family and social history.

We appreciate your time and patience in completing this document. We take this information very seriously; it is very important and can impact our medical decision making in regards to your child's care.

This form is to be completed prior to appointment time if at all possible. If a patient is over the age of twelve, it may be completed by patient with cooperation of parent as necessary. This information is confidential and intended for the use of the medical office only.

N

Springville Pediatrics, 25 E. Main St, Springville, NY 14141

Patient Name_____ Date of Birth_____

Form Completed by _____Relationship to Patient_____Today's Date_____

Birth History

___Full Term (38 to 40 weeks) ___ Pre-term # of weeks at delivery____ Name of Hospital_____

___Vaginal ___C-section (pick one) NICU Stay? __Yes __No Duration _____ (Please explain reason under "complications")

Complications? List _____

Birth wt _____Discharge wt_____ Breast Fed____Duration_____ Bottle Fed ___ Type of Formula _____

Past and Present Medical Problems (check all that apply to this child only and specify if possible):

__Allergies (Specify _____)
__Anxiety
__Asthma/Reactive Airway Dx
__ADHD
__Autism Spectrum Disorder
__Behavior Problems
__Birth Defect (Specify_____)
__Bleeding Problem (Specify_____)
__Cancer (Specify_____)
__Heart Disease/Defect (Specify _____)
__Cerebral Palsy
__Depression
__Developmental Problems (Specify_____)
__Diabetes (Type I or Type II)
__Dietary Restrictions (Specify_____)
__Down Syndrome
__Feeding Problems (Specify_____)
__Frequent Ear Infections
__Gastro Esophageal Reflux Disease (GERD)
__Communication Needs: Hearing?___ Vision?____ Speech?____
__Pneumonia – recurrent
__Seizures
__Skin Problems (Specify _____)
__ Sickle Cell Anemia
__Thyroid Problem
__Urinary Tract Infection
__Urinary Reflux
__ Other Medical Problems _____
_____

Specialty care

What specialists does this child see? _____

Were you referred to this specialist by Springville Pediatrics? ____yes _____no

List any injuries that required a doctor's care or an ER visit (ex: stitches, concussion) with approx. dates/age of child ___

_____

Surgery (check all that apply to this child only and give approximate date/age of child if known):

__None __Circumcision __ Hernia Repair __Ear Tubes __Tonsillectomy __Adenoidectomy __Other_____

Did your child have any problems with anesthesia? __Yes __No If yes, please explain.

Hospitalizations (Overnight Stay) (please list illness and approximate date/age of child)

_____

_____

Current Medications (please list ALL over the counter and prescription birth control, vitamins, herbal products, and other meds)

_____

_____

Allergies

Medication Allergies _____ Reaction_____
Other med allergies and reactions_____
Food Allergies _____Reaction_____
Other food allergies and reactions

Environmental (dust, pollen, cats, etc) list_____
_____
Latex Allergy YES NO
Bee Sting Reaction

Social History

Mother's Name_____ Maiden Name _____ DOB_____ **Father's Name**_____ DOB_____

Do parents live together? __Yes __No

Legal Guardian if other than parent: Full Name_____ Relationship_____

Who does this child live with? (Check all that apply)

__Mom ___Dad ___Step Mom: Name_____ __Step Dad: Name_____

__Brothers: Full Names and DOB_____

__Sisters: Full Names and DOB_____

__Others (please list names and relationship to child) _____

Does this child live in more than one household? YES NO If yes, please explain arrangement _____

Are there legal custody arrangements? YES NO ___Joint Custody ___Sole Custody (specify _____)

(Please provide us with a copy of most current custody papers so that we know to whom we may provide medical information)

Is this child living in foster care? YES NO If yes, Agency _____ Date of Placement_____

Has this child been adopted? YES NO

Patient Name _____ Date of Birth _____

(Social History Continued)

Who cares for this child during the day? ___Parent ___Babysitter __Daycare __Other _____
Are there pets in the household? __Yes __No List _____
Do you have smoke detectors? __Yes __No
Do you have carbon monoxide detectors? __Yes __No
Is the home smoke-free? __Yes __No __Someone in the house smokes, but not inside
If you have guns in the household, are they locked up? __Yes __No ____None in home
Does the child wear a seatbelt/car seat? __Always __Sometimes __Never
Choose one: __Seat Belt __Booster Seat __Car Seat __Rear-facing car seat
Does the child wear a bike helmet? __Always __Sometimes __Never
Does the family have difficulty meeting daily needs? food____ housing____transportation_____
Optional: Race_____ Ethnicity: Hispanic Origin? __Yes __No Primary Language _____

Family Medical History

Please note here if family history is unknown for any reason: _____

Mark any of the following that apply to the family members listed. Give more details if possible.

	Mother	Father	Siblings	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
ADHD							
Alcohol Abuse							
Allergies (specify)							
Anxiety							
Asthma							
Bypass Surgery/Stents							
Cancer (specify)							
Celiac Disease							
Crohns Disease							
Depression							
Diabetes (List Type I or II)							
Early Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Irritable Bowel Syndrome							
Kidney Disease							
Lupus							
Mental Illness (specify)							
Other learning problems							
Overweight/Obesity							
Psoriasis							
Rheumatoid Arthritis							
Stroke							
Substance Abuse							
Thyroid Disease							
Urinary Reflux							
Other:							

Signature of Person Completing Form _____

Reviewed By_____ Date_____