Springville Pediatrics

Annual Health Review

for returning patients

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.

Revised 4/2013 ln/mm Revised 8/2017 JM/mm

Springville Pediatrics

Annual Health Update for Returning Patients

Patient Name_____ Patient Date of Birth_____

Each year we need to update your child's history. This form is to report any <u>changes or updates</u> in the medical, social or family history over the past year.

MEDICAL HISTORY: ___ NO Changes

In the past year, has your child been diagnosed with any new chronic or recurring illlnesses?_____

_____

What (if any) Specialists has the child seen since their last checkup? ___ none _____

Were you referred to this specialist by Springville Pediatrics? ___yes ___no

What (if any) Surgeries has the child had since last checkup? ___none _____

List any injuries that required an urgent care or ER visit since last checkup. ___none _____

What (if any) Hospitalizations has the child had since the last checkup? ____none _____

Communication Needs: Hearing?___ Vision?____ Speech?____

MEDICATIONS: (please list ALL over the counter, prescription medications, birth control, vitamins, homeopathic and herbal remedies used). ___ **NO Medications**

_____, _____, _____

Any new allergies? __ none

Medication _____ Reaction _____

Food _____ Reaction _____

Bee Sting allergy Yes No Latex allergy Yes No

SOCIAL HISTORY:

Have there been any changes in who is living in the household sine the last checkup? __ NO Changes

Additional people who live in the Primary household (Name, DOB, and relationship)

_____

People who no longer live with in the household: (Name and relationship) _____

Does the child live in more than 1 household? ___Yes ___No

Are there legal custody arrangements? ___Yes ___No

__Joint Custody___Sole custody (specify) _____

Is the child living in Foster care? ___Yes ___No Has the child been adopted? ___Yes ___No

Patient Name_____ Patient Date of Birth_____

Please answer ALL of the Following (each year):

Who cares for the child during the day? ___ Parent ___ Babysitter ___ Daycare ___ Other ____ Self
School: Grade level _____ Receiving special services? (circle) OT PT Speech IEP
Do you have smoke detectors? ___Yes ___No Carbon monoxide detectors? ___Yes ___No
Is the home smoke free? __Yes ___No ___ Someone smokes but not inside
Are there any pets in the home? (List) _____
If you have guns in the household, are they locked up? Yes No ___None in home
Does the child wear a seatbelt/use car seat? ___Always __ Sometimes ___Never
Choose: __ rear facing car seat __ Car seat, ___ Booster Seat, __ Seat belt
Does the child wear a bike helmet? ___Always __ Sometimes ___Never
Does the family have difficulty meeting daily needs? food____ housing____transportation_____

Family History: Indicate any NEW diagnoses in the past year: ___ NO Changes

	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							
Congestive heart Failure							
COPD							
Crohn's Disease/UC							
Depression							
Diabetes (type I or II)							
Fibromyalgia							
Heart attack before age 50							
Coronary Artery disease							
High Blood Pressure							
High Cholesterol							
Irritible bowel Sydrm							
Kidney Disease							
Lupus							
Mental illness (specify)							
Learning problems							
Obesity							
Psoriasis							
Rheumatoid Arthritis							
Stroke							
Substance abuse							
Thyroid disease							
Urinary Reflux							
Other:							

Signature of person completing this form_____Date_____

Reviewed by_____