GVH GRAND VIEW HEALTH

Grand View Medical Practices Pediatric Health History Form

Date:_____

Name:_____ Birth Date: _____ Age: _____ Sex: ❑ M ❑ F

Person completing form _____ Relationship to Patient _____

Patient previous doctor: _____

Social History

Please list all people in the household:

Name:	Age	Relationship

The child's parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Unmarried but living together

Have there been any recent major change or stresses in the child's life? ☐ YES ☐ NO

If yes, Please explain: _____

_____

Does your child go to school, pre-school, a baby-sitter or day-care regularly? ☐ YES ☐ NO

Name of School _____

Pregnancy & Birth History

During pregnancy did the mother:: ☐ Smoke ☐ Use Drugs ☐ Drink Alcohol ☐ Have Medical Problems ☐ Use any Medication

If yes, please explain _____

_____

Birth Weight: _____ Length: _____ Place: _____

Delivered by: ☐ Vaginal delivery ☐ Cesarean How long did the child stay in the hospital? _____

Any Birth Complications? ☐ YES ☐ NO Any complications in the newborn period? ☐ YES ☐ NO

If yes, please explain: _____

Hepatitis B vaccine given in hospital? ☐ YES ☐ NO

Past Medical History

Does your child have any of the following conditions? Please check off all that apply:

- ☐ Asthma / Allergies / Eczema
- ☐ Broken Bones
- ☐ Diabetes
- ☐ Behavior Disorders
- ☐ Croup
- ☐ Pneumonia
- ☐ Seizures
- ☐ Poisoning / Accidents
- ☐ RSV
- ☐ Anemia
- ☐ Heart Disease
- ☐ Frequent ear infections
- ☐ Kidney / Bladder problems
- ☐ Neurologic Disorder
- ☐ Menstrual Irregularities

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Has your child ever been hospitalized overnight? If yes, please explain: _____

_____

Name: _____ **Date:** _____

Please list any surgeries your child has had: _____

Please list any medications you child takes: _____

_____

Family History

Does any one on the child's family have any of the following conditions? Please check appropriate boxes

☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease ☐ Allergies / Asthma / Eczema
☐ Cancer ☐ Diabetes ☐ Blood Disease ☐ Seizures
☐ Alcoholism ☐ Tuberculosis ☐ Mental / Emotional Problems

If yes, please explain: _____

_____

Developmental History

At what age did your child: Sit alone: _____ Say words: _____
Walk alone: _____ Toilet Train (daytime): _____
Girls only: age at first menstrual period: _____

Nutrition / Feeding / Sleep / Home

Was your child breast fed? ☐ YES ☐ NO If so, how long? _____
Has your child had any unusual feeding / dietary problem? If yes, please explain _____

_____

How many hours does your child sleep at night? _____

Naps (number and length) _____

Any concerns about lead exposure? (Old home / plumbing /paint) ☐ YES ☐ NO

Do any household members smoke? ☐ YES ☐ NO

Hours / day spent: Watching TV _____ Computer _____ Video Games _____

Immunizations

********** Please bring immunization records to your appointments **********

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

Does your insurance cover immunization? ☐ YES ☐ NO (if "no", your child may be eligible for free immunizations)

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PATIENT INFORMATION

Name (Last, First, Middle)	Employer Name
Date of Birth: Sex: ☐M ☐F ☐Unk	Employer's Address
Address	Employer's Phone #
City State Zip	Employer Status ☐ Full time ☐ Part time ☐ Retired ☐ Active Military ☐ Self Employed ☐ Unemployed
Email	Occupation
Primary Care Physician:	Pharmacy Name and Location
Referring Physician	

Communication Preferences

Phone Numbers

Cell:	Marital Status _____
Home:	Preferred Language _____
Work:	Interpreter Needed: ☐ Yes ☐ No
Preferred Phone # ☐ Cell ☐ Home ☐ Work	Ethnicity: ☐ Non Hispanic ☐ Other _____ ☐ Hispanic ☐ Unknown
OK to leave voice mail regarding appointment, clinical, or financial information? ☐ Yes ☐ No	Race: ☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other ☐ Patient Declined

Emergency Contact

Name (Last, First, Middle):	Permission to Disclose Healthcare Information ☐ Yes ☐ No
	Regarding Appointments? ☐ Yes ☐ No
Relationship to Patient:	Regarding Clinical Information? ☐ Yes ☐ No
Phone # ☐ Cell ☐ Home ☐ Work	Regarding Financial Information? ☐ Yes ☐ No

Person Financially Responsible ☐ check here if self

Name (Last, First, Middle)	Relationship to Patient
Address	Home Phone
City State Zip	Cell Phone

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name	Insurance Name
Subscriber Name	Subscriber Name
Subscriber DOB	Subscriber DOB
Policy Number	Policy Number
Group Number	Group Number
Effective Date	Effective Date

Patient or Guardian Signature _____ Date _____