Generations Family Health NPs
Patient Name: _____ DOB: ____ / ____ / _____

Pediatric Initial History Questionnaire

Household & Birth History

- List all those living in the child's home (Name / Relationship to Child / DOB):
  _____
  _____
  _____
  _____
- Are there siblings not listed above? □ Yes □ No
- If yes, list names, ages, and where they live:
  _____
  _____
- Mother's Maiden Name: _____
- Living situation (check one): □ Both parents □ Joint custody □ Single custody
  □ Adoptive parents □ Foster family
- If one or both parents live outside the home, how often does the child see them?
  _____
  _____
- Birth weight: _____ lb _____ oz Born at: ____ weeks gestation
- Delivery: □ Vaginal □ Cesarean (If cesarean, why? _____)
- Prenatal/neonatal complications? □ No □ Yes – Explain:
  _____
  _____
- NICU stay? □ No □ Yes – Explain:
  _____
  _____
- During pregnancy, did mother:
  - Use tobacco? □ Yes □ No
  - Drink alcohol? □ Yes □ No
  - Use drugs or medications? □ No □ Yes – What/When:_____
- Initial feeding: □ Formula □ Breastfed – For how long? _____
- Did your baby go home from the hospital with mother? □ Yes □ No – Explain:
  _____
  _____

General Health

- Do you consider your child to be in good health? □ Yes □ No – Explain:
  _____
- Serious illnesses or conditions? □ No □ Yes – Explain:
  _____
- Surgeries? □ No □ Yes – Explain:
  _____

- Hospitalizations? □ No □ Yes – Explain:
  _____
- Medication or food allergies? □ No □ Yes – Explain:
  _____
- Does your family have enough food to eat? □ Yes □ No – Explain:
  _____
- Does anyone smoke in the home? □ No □ Outside □ Inside

Patient's Past Medical History (check all that apply):

- ☐ Asthma / wheezing
- ☐ Allergies (food/meds/environmental)
- ☐ Ear/hearing problems
- ☐ Eye/vision problems
- ☐ Heart murmur / heart condition
- ☐ High blood pressure
- ☐ Seizures / neurological problems
- ☐ Frequent headaches / migraines
- ☐ Constipation
- ☐ Cancer, type _____
- ☐ Sleep problems
- ☐ Skin issues (eczema, rashes)
- ☐ Diabetes
- ☐ Thyroid or other endocrine problems
- ☐ Blood problems (anemia, bleeding, clotting)
- ☐ Anxiety / depression
- ☐ ADHD / developmental / learning concerns
- ☐ Autism
- ☐ Kidney or urinary problems
- ☐ Bed-wetting (after age 5)
- ☐ Chickenpox
- ☐ Genetic disorders
- ☐ Obesity
- ☐ Serious injuries / concussions
- ☐ Fractures, location _____
- ☐ Use of alcohol or drugs
- ☐ Tobacco use / vaping
- ☐ Dental problems
- ☐ History of family violence
- ☐ STDs
- ☐ Other: _____
- ☐ For females, if applicable:
  - ☐ Problems with period
  - ☐ Pregnancy
  - ☐ Age of 1st period: _____

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Family History

Indicate if your child's family members have any of these diseases

Disease	Mother/Maternal Side			Father/Paternal Side			Siblings (names:)		
	Mom	MGM	MGF	Dad	PGM	PGF			
Asthma									
ADHD									
Allergies									
Autoimmune disease, Type:									
Heart disease / heart attack									
High cholesterol									
High blood pressure									
Diabetes									
Breast cancer									
Colon cancer									
Cancer, type:									
Seizures / neurological problems									
Migraines									
Stroke									
Mental illness									
Depression / anxiety									
Developmental disability									
Autism									
Alcohol use disorder									
Drug use disorder									
Blood disorders									
Liver disease									
Kidney disease									
Lung disease									
Pulmonary embolism									
Obesity									
Tobacco use									
Other:									
Other:									

Generations Family Health NPs
Patient Name: _____ DOB: ____ / ____ / _____

Authorization for Medical Treatment of a Minor in My Absence

1. I hereby state that I am the Parent(s)/Legal Guardian of the child(ren) named below and there are no court orders now in effect that would prohibit the exercise of the power that I/we now seek to authorize for the treatment of our child(ren).

2. In the event I am unable to bring the child(ren) listed below for medical treatment this designation permits:

    a. Name: _____ Relationship: _____ Phone: _____
    (Authorized Adult Over 18)

    b. Name: _____ Relationship: _____ Phone: _____
    (Authorized Adult Over 18)

    to act on my behalf and give consent for health care services to the following child(ren):

    Name: _____ DOB:___ /___/_____ Allergies: _____

    Name: _____ DOB:___ /___/_____ Allergies: _____

    Name: _____ DOB:___ /___/_____ Allergies: _____

    Name: _____ DOB:___ /___/_____ Allergies: _____

3. **Effective Dates:** From ___/___/_____ to ___/___/_____ (max 1 year – must be updated annually)

4. As to the above named child(ren), the designee is authorized to: *(Parents please check all that apply below)*

    - ☐ Consent to Immunizations/therapeutic injections
    - ☐ Consent to Mental Health examinations/treatment
    - ☐ Consent to General Healthcare, including examination and treatment, minor medical treatment and for emergency care.
    - ☐ Consent to Developmental Screening

    The designee's authority is limited as follows:_____
    _____

5. **Revocation:**
    a. A parent may revoke an authorization at will, and may notify relevant health care providers in writing of such revocation.
    b. A designee, who receives notification from a parent of such revocation, shall forthwith notify any health care provider or health plan to which an authorization pursuant to this subdivision has been presented. Failure by the designee to notify recipients of the authorization or the revocation shall not make notification of revocation by the parent ineffective.
    c. If the parent who signed a designation becomes incapacitated or dies, the designation is revoked.
    d. Long-term care of child(ren) parent may wish to seek a more permanent legal arrangement by commencing a judicial proceeding to appoint legal guardianship or to determine custody.

6. **Signature and date:** If a court has ordered that both parents must agree on healthcare decisions, both parents are required to sign this form.

Parent/Guardian Name: _____ Relationship: _____
Signature: _____ Date: ___/___/_____
Address: _____ Phone: _____

Parent/Guardian Name: _____ Relationship: _____
Signature: _____ Date: ___/___/_____
Address: _____ Phone: _____

Witness (If signed in office):

Employee who verified ID of consenting parent and witnessed their signature; sign and date below:

Name: _____

Signature: _____ Date: ___/___/_____