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## NEW PEDIATRIC PATIENT HISTORY INTAKE

Welcome to **High Tech Family Care**. In order for us to better serve you; please take the time to fill out this entire packet as accurately as possible so we can adequately address your health needs and/or concerns.

## CHILD’S PERSONAL HISTORY

Name *(legal):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name (*preferred*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female Social Security #: \_\_ - \_\_\_ - \_\_

Date of Birth / / Age: \_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home (\_\_\_) Cell (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity? White/Caucasian Black/African American Asian/Pacific Islander Hispanic/Latino

Native American Other

**PARENT’S INFORMATION**

Child's School

Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child lives with: Father Mother Both Other

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_Age:\_\_\_\_\_\_

Telephone: Home ( ) Cell ( )

Email Address:

Occupation:

Are we authorized to send lab results or medical interface to this email address? NO YES

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_Age:\_\_\_\_\_\_

Telephone: Home ( ) Cell ( )

Email Address:

Occupation:

Are we authorized to send lab results or medical interface to this email address? NO YES

**INSURANCE INFORMATION**

Primary Insurance Carrier’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Social Security #: \_\_ - \_\_\_ - \_\_

Name & Address of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature below indicates your consent for treatment of patient and your responsibility for payment of services provided. Thank you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Parent Signature Date:

Date of Last Examination

Child's Previous Pediatrician: Tel: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:

|  |  |
| --- | --- |
| **ALLERGIES (DRUG OR FOOD):** | **Reaction(s)** |
|  |  |
|  |  |
|  |  |
|  |  |

**REASON FOR THIS VISIT:**

|  |  |  |
| --- | --- | --- |
| **Current Medications** | **Dose** | **Times / Day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Current Herbs / Vitamins/ Supplements** | **Dose** | **Times / Day** |
|  |  |  |
|  |  |  |
|  |  |  |

**BIRTH HISTORY: Past Medical, Surgical & Trauma History Personal And Family History**

Mother's age at birth: Complications during pregnancy? NO YES

If "yes”, explain:

Birth weight: \_\_\_\_\_ (*lbs*) \_\_\_\_\_ (*oz*) Bottle Fed Breast Fed

Complications during/after birth? NO YES ***If "yes”, explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the baby full term? NO YES Delivery: Vaginal C-Section

Birth Hospital (for newborns only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**: (*Please check all that applies to your child)*

Recurrent ear infections ADHD/ADD

Recurrent sore throat Autism Spectrum

Asthma Allergies

Heart murmur Diabetes

Seizures Down Syndrome

Eczema

Provided immunization record? NO YES Are immunizations current? NO YES

Ever been seen by a specialist? NO YES ***If “yes” explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **PAST MEDICAL, SURGICAL & TRAUMA HISTORY**  *List prior illnesses, injuries, hospitalizations, surgeries, and/or traumas:* | |
| **Condition** | **Date(s)** |
|  |  |
|  |  |
|  |  |
|  |  |

Last Dental Visit:

Any additional important health history:

## SOCIAL HISTORY:

Does anyone in the house smoke? NO YES ***If “yes,” who?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets? NO YES ***If “yes,” what type of pets?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child enrolled in daycare? NO YES

Is the child enrolled in school? If so, current grade level: \_\_\_\_\_\_ Failed/failing grades? NO YES

Problems in school? NO YES ***If “yes,” explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours does your child sleep in a day? \_\_\_\_\_

Water supply at home: City/Municipal Well Are there any problems with your home? \_\_\_\_\_\_\_\_\_\_\_

What year was the home/apartment built? \_\_\_\_\_\_\_\_\_ Paint chipping on the wall? NO YES

Any recent travel? NO YES ***If “yes,” when/where***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language spoken at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been exposed to anyone who has been recently incarcerated, or had Tuberculosis?

NO YES ***If “yes,” explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child smoke? NO YES Use drugs? NO YES

Drink alcohol? NO YES Have history of depression? NO YES

Drink caffeine? NO YES Suicide attempts? NO YES

## DIET:

What type of milk does your child drink? Whole 2% Skim Formula (type) \_\_\_\_\_\_\_\_\_\_\_\_

How much milk is typically consumed in 24 hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many ounces of juice or soda does your child drink per day? \_\_\_\_\_\_\_\_\_\_\_

Does your child eat non-food materials (dirt/paper, etc)? NO YES If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns about your child’s diet? NO YES ***If “yes,” explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SAFETY:

Do you have a smoke detector? NO YES What is your water heater temperature? \_\_\_\_\_\_\_\_

Is your home child proof? NO YES Any guns in the house? NO YES

Does home have a swimming pool? NO YES

What child-accessible medications do you have in your medicine cabinet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## FAMILY HISTORY:

Does the child's mother/father have any medical problems? NO YES ***If “yes,” explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all children in the home:**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_age: \_\_\_\_\_ male female

General health status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_age: \_\_\_\_\_ male female

General health status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_age: \_\_\_\_\_ male female

General health status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_age: \_\_\_\_\_ male female

General health status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any deceased siblings? NO YES ***If “yes,” explain***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Has any blood relative ever had the following?

Cancer, including Leukemia NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Trouble NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Attack NO YES If “yes” at what age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorder NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraine Headaches NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcoholism NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Defects NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sudden Death NO YES If “yes” who/cause of death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIDS NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS NO YES If “yes” who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Other Serious Disease NO YES If “yes” who/what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## GROWTH & DEVELOPMENT

At what age did your child sit up alone? At what age did your child start walking? At what age did your child start talking? How does your child compare to other children his/her age?

|  |  |  |  |
| --- | --- | --- | --- |
| **EMERGENCY CONTACT** *(When parent/guardian is unable to be reached)* | | | |
| **NAME** *(list at least 3 contacts)* | | **PHONE** | **RELATIONSHIP** |
| **1.** |  |  |  |
| May we disclose all medically needed documents to this emergency contact? NO YES | | | |
| **2.** |  |  |  |
| May we disclose all medically needed documents to this emergency contact? NO YES | | | |
| **3.** |  |  |  |
| May we disclose all medically needed documents to this emergency contact? NO YES | | | |
| **Advance Directive:** Full code *or* Do Not Resuscitate | | | |

This history record has been designed to facilitate our patient’s continuity of care at **High Tech Family Care**. This is a confidential record. Information contained here will not be released without proper written authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Physician Signature Date Signed*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Printed name of individual completing form*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of individual completing form Date Completed*