MV Pediatrics

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Please help us get to know your child better by answering the questions on both the front and back of this form.

Name: _____ Date of Birth: _____

PCP: _____ Date of Visit: _____

Race/Ethnicity: ❑White-Non-Hispanic ❑Black- Non-Hispanic ❑Hispanic oAsian ❑Native American
❑Native Hawaiian and Other Pacific Islander ❑Other: _____

Current Health Concerns:

PAST MEDICAL HISTORY

Birth Hospital: Pregnancy Problems? oYes ❑ No Problem in Nursery? o Yes ❑ No

Birth Weight: _____ Labor/Delivery Problems? oYes ❑ No Did baby go home with mom? oYes ❑ No
Discharge Weight: _____ with mother? oYes ❑ No Was baby breast fed? oYes ❑ No
Discharge Date: _____ with baby? oYes ❑ No Hg
Pregnancy Duration: _____
Problems in first few months? _____
Chronic illness/injuries? _____
Hospitalizations/surgeries? _____
Behavior issues? _____
School issues? _____
Interests/Activities: _____
Recurrent problems? _____
Location of previous pediatric care: _____

ALLERGIES

Allergic to any medications? ❑ No ❑ Yes List: _____
Adverse reaction to medications? ❑ No ❑ Yes List: _____
Allergic to any foods? ❑ No ❑ Yes List: _____
Other allergies? ❑ No o Yes List: _____

MEDICATIONS

List all medications you currently take including prescription medications, over-the-counter medications and herbal remedies.
(please include dose if known)

SOCIAL HISTORY

Mother's first name: _____ Age: _____ Occupation: ___ _____
Father's first name: _____ Age: _____ Occupation: ___ _____
Parents married? ❑ Yes ❑ No Parents living together? ❑ Yes ❑ No
Child's daytime caregiver? _____ _____
Others living in your home? ___ _____
Siblings names, genders and ages: _____

FAMILY HISTORY

Please check if there is a family history of any of the following problems noted below
(mother, father, siblings, grandparents, aunts, uncles and cousins)

Problem	Relationship	Maternal/Paternal	Problem	Relationship	Maternal/Paternal
❑ADD		❑ M ❑ P	❑Eczema		❑ M ❑ P
❑Alcohol Abuse		❑ M ❑ P	❑Heart Disease		❑ M ❑ P
❑Allergy		❑ M ❑ P	❑High Blood Pressure		❑ M ❑ P
DAsthin a		❑ M ❑ P	❑Kidney		❑ M ❑ P
❑Birth Defect		❑ M ❑ P	❑Mental Illness		❑ M ❑ P
❑Cancer		❑ M ❑ P	❑Obesity		❑ M ❑ P
❑Skin Cancer		❑ M ❑ P	❑School Problems		❑ M ❑ P
❑Cholesterol (high)		❑ M ❑ P	❑Seizures		❑ M ❑ P
❑Developmental		❑ M ❑ P	❑Stomach/Bowel		❑ M ❑ P
❑Diabetes		❑ M ❑ P	❑Thyroid		❑ M ❑ P
❑Drug Abuse		o M o P			o M o 13
Any other medical condition that "runs" in the family?					

DEVELOPMENTAL BEHAVIOR

Problems with eating? ❑ No ❑ Yes
Problems with sleeping? ❑ No ❑ Yes
Problems with elimination? ❑ No ❑ Yes
Problems with temper? ❑ No ❑ Yes
At what age did your child sit alone? _____
At what age did your child walk? _____ Do you have any concerns about your child's development? _____

Problems in school? ❑ No ❑ Yes
Problems with peers/siblings? ❑ No ❑ Yes
Problems with behavior? ❑ No ❑ Yes
Problems with toilet training?
At what age did your child speak words? _____

SAFETY ENVIRONMENT

Does your child always wear a seat belt? ❑ No❑ Yes
Does your child always wear a helmet? ❑ No❑ Yes
Do you have working smoke detectors? ❑ No❑ Yes
Do you have a carbon monoxide detector? ❑ No❑ Yes

Are there smokers at home? ❑ No ❑ Yes
Does your home contain lead paint? ❑ No ❑ Yes
Do you have any firearms in the home? ❑ No ❑ Yes
If yes, is ammunition stored separately? ❑ No ❑ Yes

TUBERCULOSIS SCREEN

Has your child lived with or spent time with anyone who was positive for tuberculosis? ❑ No ❑ Yes
Has your child lived or spent time with anyone who has a positive skin test for tuberculosis? ❑ No ❑ Yes
Has anyone in your household come to the United States from another country? ❑ No ❑ Yes
Has your child lived with or spent time with adults who were homeless or lived in a shelter? ❑ No ❑ Yes
Has your child lived with or spent time with adults who have AIDS or are infected with HIV? ❑ No ❑ Yes
Has your child lived with or spent time with adults who used intravenous drugs or other street drugs? ❑ No ❑ Yes
Has your child lived with or spent time with adults who lived in a correctional facility, nursing home, or mental institution? ❑ No ❑ Yes

If your child has had a positive skin test for tuberculosis in the past, inform your child's healthcare provider. Your child will not need another test.

PATIENT ELIGIBILITY SCREENING FORM

(please check one only)

❑This child is enrolled in Medicaid (includes Mass Health and HMO's, etc. if enrolled through Medicaid).
oDoes not have health insurance. (also check this box for children enrolled in the Children's Medical Security Plan.) ols Native American (American Indian) or Alaskan Native.
❑Has health insurance and is not Native American (American Indian) or Alaskan Native.

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____