(please read & complete front & back)

Student Name: Last: _____ First: _____ Birth Date: _____ Age: _____

Northeast Health Center (NHC)
Parkside Health Center (PHC)
Jackson High Health Center (JHHC)
Northwest Community Health Center (NWCHC)
Pediatric Patient History

Male ☐ Female ☐	Address:	City:	Zip code:	Telephone #'s: Home: ( ) _____ Other: ( ) _____
Grade:	School:	Primary Language Spoken: By patient_____ In home _____		

Parent/Guardian
(1) Last Name _____ First Name: _____ Birth date: _____

Relationship to Student: _____ Daytime telephone: _____ Work telephone: _____

Cell/Pager _____

(2) Last Name _____ First Name: _____ Birth date: _____

Relationship to Student: _____ Daytime telephone: _____ Work telephone: _____

Cell/Pager _____

Name of Emergency Contact (other than parent):	Relationship:	Telephone #:
Name of Student's Physician:	Name of Student's Dentist:	Date of last dental visit:

Insurance – Medical	Policy #:
Insurance – Dental	Policy #:

Subscriber:	Birth Date:	Relationship to Student:

INFORMATION NEED FOR FEDERAL FUNDING (this information is not used on an individual basis)

Income $_____ ☐ Annual ☐ Monthly ☐ Weekly

Race: ☐White ☐ Black ☐ Pacific Islander ☐ Asian ☐ American Indian ☐ More than 1 ☐ Unknown
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown
Total Number Living in Household? _____
Census: ☐ Patient lives in City of Jackson ☐ Patient lives in County of Jackson ☐ Patient lives outside County of Jackson

Name of Medication:	Dose:	How Often:

Preferred Pharmacy:

Please list all allergies:

PREGNANCY AND BIRTH HISTORY		
Mother's age at birth _____	**Did mother receive prenatal care?** ☐ Yes ☐ No	
Any problems/illness during pregnancy?	☐ Diabetes during pregnancy	☐ Sickle Cell Trait
	☐ Diabetes before pregnancy Insulin Dependent? ☐ Yes ☐ No	☐ Heart Disease
	☐ High blood pressure during pregnancy	☐ Kidney Disease
	☐ High blood pressure before pregnancy	☐ Infection during pregnancy (if yes, type of infection)
	☐ Surgery during pregnancy (if yes, type of surgery)	
	☐ Other:	
Use during pregnancy?	☐ Alcohol	☐ Marijuana
	☐ Tobacco	☐ Other Drug Use:
Type of delivery	☐ Vaginal delivery ☐ Cesarean section emergency ☐ Cesarean section - Elective	
	☐ Forceps ☐ Vacuum assisted	
Did baby come on time?	Weeks at delivery: _____ (40 weeks-full term)	
Birth Weight / Length?	**Birth Weight _____ pounds _____ ounces Birth Length _____ inches**	
Any problems with delivery or with baby at birth?	☐ Oxygen needed	
	☐ Evaluated for Infection	
	☐ Jaundice ☐ Phototherapy	
	☐ Admitted to special care nursery or neonatal intensive care (if checked, please give reason) # of days in nursery _____	

PAST MEDICAL HISTORY – *Please mark any that apply to your child*		
Cardiac ☐ Heart murmur ☐ High blood pressure ☐ Rheumatic fever Other: _____	*Respiratory* ☐ Asthma ☐ Breathing treatments Machine at home? ☐ Yes ☐ No ☐ Shortness of breath ☐ Sleep Apnea Other: _____	*Genitourinary* ☐ Bed wetting ☐ Frequent urination ☐ Frequent urine infections ☐ Kidney or bladder problems Other: _____

Neuropsych	*HEENT*	*Musculoskeletal*
☐ ADD/ADHD ☐ Anxiety ☐ Cutting behavior ☐ Depression ☐ Eating disorder ☐ Seizures Other: _____	☐ Frequent ear infections Tubes? ☐ Yes ☐ No ☐ Frequent sore throats ☐ Headaches ☐ Hearing problems ☐ Nosebleeds ☐ Vision problems Glasses? ☐ Yes ☐ No Other: _____	☐ Broken bone part of body?_____ ☐ Flat feet ☐ Pain in joints Other: _____
Hematologic/Neoplastic	*Dermatologic*	*Immunologic*
☐ Anemia ☐ Cancer ☐ Sickle cell disease Other: _____	☐ Acne ☐ Eczema ☐ Hives/Rash ☐ Warts Other: _____	☐ Bee sting allergies ☐ Food allergies Type: _____ ☐ Hay fever ☐ Latex allergy ☐ Medication allergy (see allergies on page 2) ☐ Pet allergies Other: _____
Infectious Disease	*Gastrointestinal*	*Metabolic*
☐ Chlamydia ☐ Gonorrhea ☐ HIV ☐ MRSA ☐ RSV Other: _____	☐ Constipation ☐ Diarrhea ☐ Stomach pain Other: _____	☐ Diabetes Other: _____

Overnight Hospitalizations? ☐ Yes ☐ No (if yes, please explain)

Surgeries? ☐ Yes ☐ No (if yes, please list surgeries and dates)

SOCIAL HISTORY

Child Lives With:

☐ **Mother** ☐ **Sisters** **Other**_____

☐ **Father** ☐ **Brothers** **Other**_____

☐ **Step Father** **Other**_____

☐ **Step Mother** **Other**_____

Is the child in daycare: ☐ Yes ☐ No

Smoking in the house? ☐ Yes ☐ No **Outside only?** ☐ Yes ☐ No

Water source: ☐ Well water ☐ City water

Lead in home? ☐ Yes ☐ No ☐ Unknown

Smoke detectors in home? ☐ Yes ☐ No

Pets in the home? ☐ Yes ☐ No Type: _____

Name of school attending: _____ **Grade:** _____

Learning disability? ☐ Yes ☐ No

Any sleep problems/Nightmares? ☐ Yes ☐ No

Siblings	**Gender**	
Name:_____	☐ Male ☐ Female	**Date of Birth:**_____
Name:_____	☐ Male ☐ Female	**Date of Birth:**_____
Name:_____	☐ Male ☐ Female	**Date of Birth:**_____
Name:_____	☐ Male ☐ Female	**Date of Birth:**_____

FAMILY HISTORY

Mother's date of birth _____

☐ **Family History Unknown - Patient adopted**

Father's date of birth _____

Please mark any that apply to child's family members

Diagnosis	**Patient's Father**	**Patient's Mother**	**Patient's Sister**	**Patient's Brother**	**Other Relative**
Anxiety					
Asthma					
Alcoholism					
Blood Disease					
Heart disease					
Cancer					
Depression					
Diabetes					
Hearing loss					
High cholesterol					
High blood pressure					
Learning disability					
Mental Illness					
Migraines					
Obesity					
Renal disease/kidney problems					
Seizure disorder					
Sickle cell disease					
Stroke					
Substance abuse					
Thyroid disease					
Tuberculosis					
Other					
Other					
Other					

Family members deceased	**Cause of death:**	**Age at death:**
☐ Patient's Father	☐ Father_____	☐ Father _____
☐ Patient's Mother	☐ Mother_____	☐ Mother _____
☐ Patient's Sister	☐ Sister _____	☐ Sister _____
☐ Patient's Brother	☐ Brother _____	☐ Brother _____

Provider Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date: _____