central+ priority PEDIATRICS

Patient Label

Please complete this form as thoroughly as possible. As we transition to an electronic medical record, completing this form *one* time will help us to create a complete record for your child. We can then update any changes as needed at subsequent well child visits. Thank you.

Child's Medical History (circle all that apply)

1. Medical problems: None asthma allergies breathing problems constipation diabetes
frequent ear infections stomach reflux kidney reflux other:__________________

2. Serious injuries: ☐ None ____

3. School and developmental issues: None ADHD autism developmental delay speech delay other: ___________

4. Mental health issues: None anxiety depression other:_____________

5. Other illnesses or problems: ☐ None ____

Allergies ☐ None

Meds/Foods	Reaction (hives, anaphalaxis,etc)

Hospitalizations ☐ None

Month/Year	Reason

Surgeries ☐ None

Month/Year	Reason

Social History

1. What is your child's living situation? ☐ Single home ☐ More than one home ☐ Foster home ☐ Group home ☐ Sheltered housing ☐ Homeless

2. With whom does your child live? (circle all that apply) ☐ Both parents together ☐ Parents separately ☐ Father ☐ Mother ☐ Sibling(s) ☐ Step-parent(s) ☐ Grandparent(s)

Household #1

Name	Relationship to patient

Household #2

Name	Relationship to patient

3. Parent's marital status: married divorced separated single other:_________________________

4. Is the child adopted? No Yes If yes, from where? ______________________________________

5. Daycare status: ☐ home daycare ☐ center daycare ☐ before/after school program ☐ at home with nanny/babysitter
☐ at home with family member ☐ at home with mother ☐ at home with father ☐ at home with grandparent
☐ other:

____M.D.

Continue on back.

Biological Family Medical History

Biological family member:	Status (living, deceased)	Year of birth	Asthma	Allergies	Heart disease < 55 yrs old	High blood pressure	High cholesterol	Stroke	Diabetes	Mental illness	Cancer	Bleeding disorder	Reaction to anesthesia	Unknown	Other (please specify):
Father															
Mother															
Paternal Grandfather															
Paternal Grandmother															
Maternal Grandfather															
Maternal Grandmother															
Sibling:______________															
Sibling:______________															
Sibling:_______________															
Other:_______________															

For office use only:

Reviewed by:____________MD

Entered by:______________

Date entered:_____________

Revised 12/2015