Community Pediatric Specialists
726 Medical Center Drive East, Suite 209 Clovis, CA 93611
Phone: 559.325.5656 | Fax: 559.325.5568

COMMUNITY HEALTH PARTNERS

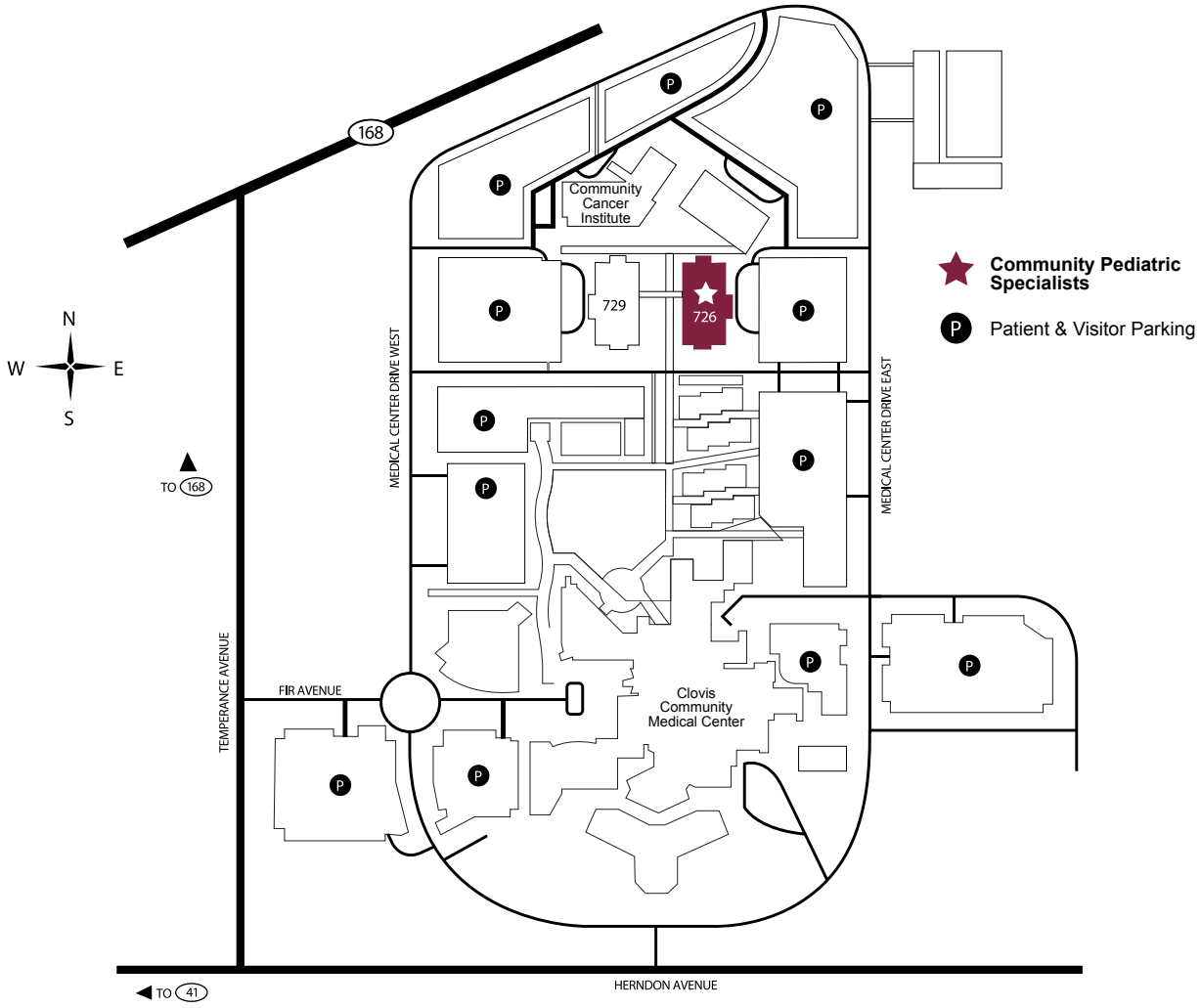
Patient Name: _____

You have an appointment with: _____

Monday **Tuesday** **Wednesday** **Thursday** **Friday** _____ AM / PM

Community Pediatric Specialists

We are a very unique pediatric office since we have an affiliation with UCSF. All our physicians are faculty physicians with UCSF and they treat patients, conduct research and teach the next generation of Pediatricians and Pediatric Specialists. Approximately 40% of all physicians remain and practice medicine in the area where they went through their residency training. This is wonderful for our community. Not only are we bringing the expertise of UCSF to Fresno, we are also creating more pediatricians for the smallest members of our community.



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Pediatric Health History Questionnaire

			Date:
Patient Name:			
Date of Birth:	Age:	Sex: ☐ Male ☐ Female	Weight: lbs:

HISTORY OF PRESENT ILLNESS

Reason for being seen today? (Chief Complaint)

What symptom(s) does your child have?

Does anything make the symptoms better or worse?

How long have the symptoms been present?

What tests have been done, if any?

What treatments and/or medications have been (or were) given? *List current medications below.*

CURRENT MEDICATIONS		
Name:	Dosage:	Times per day:
What is your preferred pharmacy?		

ALLERGIES

Does your child have a **MEDICATION** allergy? ☐ Yes ☐ No	Immunizations: Is your child up to date for his/her age? ☐ Yes ☐ No
Please list allergies: _____	

BIRTH HISTORY

PREGNANCY	Complications during pregnancy (infection, baby too small, poor movements)?	☐ Yes ☐ No	
DELIVERY	Was the baby premature? Gestational Age? ☐ Yes ☐ No	Birth weight? _____ Lbs. _____ Oz.	
	Any complications after birth (jaundice, breathing, feeding problem, infection)? ☐ Yes ☐ No	Birth length?_____ Inches	

PATIENT MEDICAL HISTORY

Please check if you haver or ever had the following:

ADHD ☐	Depression ☐	Otitis media ☐
Allergies ☐	Developmental delay ☐	Pneumonia ☐
Anesthetic complications ☐	Diabetes mellitus ☐	Prematurity ☐
Asthma ☐	Dizziness ☐	Renal disorders ☐
Bleeding problems ☐	Eczema ☐	Rhinitis ☐
Blood Disease ☐	Failure to thrive ☐	Scoliosis ☐
Bronchiolitis ☐	Genetic ☐	Seizures ☐
Cancer ☐	GERD ☐	Sickle cell anemia ☐
Cerebral Palsy ☐	Headaches ☐	Snoring ☐
Chest Pain ☐	Hospitalizations ☐	Strep throat (recurrent/frequent ☐
Chronic Constipation ☐	Hypertension ☐	Syncope ☐
Colitis/Bowel Disease ☐	Immune disorder ☐	TB exposure ☐
Congenital Heart Disease ☐	Liver Disease ☐	Vaccine refusal ☐
Crohn's Disease ☐	Migraines ☐	Valley fever ☐
Croup ☐	Near Syncope ☐	Venous malformation ☐
Cystic fibrosis ☐	Obesity ☐	

PATIENT SURGICAL HISTORY

Please check if you haver or ever had the following:

Abdomen surgery ☐	Cleft palate/lip ☐	Orthopedic surgery ☐
Adenoidectomy ☐	EGD/Endoscopy ☐	Scoliosis surgery ☐
Appendectomy ☐	Gastrostomy ☐	Tonsillectomy ☐
Baclofen pump ☐	Heart surgery ☐	Tracheostomy tube ☐
Bronchoscopy ☐	Laryngoscopy ☐	VP Shunt ☐
Central Line ☐	Myringotomy (ear tubes) ☐	Other: ☐

FAMILY HISTORY

Do any of your immediate family members have a history of:

			Sibling(s)		Maternal Grandparent		Paternal Grandparent	
	Mother	Father	Brother	Sister	Grandma	Grandpa	Grandma	Grandpa
Adopted								
Allergies								
Arrhythmia								
Arthritis								
Asthma								
Birth Defects								
Cancer								
Congested Heart Failure								
Cystic Fibrosis								
Depression								
Developmental Delay								
Diabetes								
Dizziness								
Early Death								
Fainting								
Healthy								
Heart Disease								
High Cholesterol								
History Unknown								
Hypertension								
Mental Illness								
Pacemaker								
Sleep Apnea								
Sudden Death								
Vision Loss								
Other								

DEVELOPMENTAL/SOCIAL

Do you or do you now feel that your child was slow in his/he development of:

Speech/Language	☐ Yes ☐ No	Explain:
Social Skills	☐ Yes ☐ No	Explain:
Motor Skills	☐ Yes ☐ No	Explain:
Is patient exposed to second hand tobacco smoke?		
Have you traveled outside the U.S. in the last year?		
Do you have animals at home?		

Your previous medical records are important in providing us with a complete picture of your past medical history and current medical treatment. Did you bring them with you today? ☐ Yes ☐ No

If no, please speak to the front desk and make arrangements to provide us with this information.

Filled out by *(please print)*: _____ Relationship: _____

Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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Consent for Medical Treatment

This form gives permission to an authorize to an authorized person to obtain medical treatment for their minor child when the PARENT/LEGAL GUARDIAN cannot bring their child to an appointment.

Today's Date:_____

RE:_____ (Patients Name) **Date of Birth:** _____

I thereby authorize the below named person to obtain medical treatment for my minor child in my absence.

This authorization allows my physician or his/her office staff to release and discuss any/all test results to the family member listed, including but not limited to: lab test, x-ray results and office visit treatment options and diagnosis.

Name of person who has my permission to seek medical treatment for my child:

_____

Relationship to patient:

☐Step Mother ☐Step Father ☐Grandmother ☐Grandfather ☐Aunt ☐Uncle

Siblings (must be 18 years old or older) / Other (specify relationship):

_____

This authorization is good for the duration of (check any):

☐Today's visit only ☐Well-child (physical)
☐Any type of appointment, specific dates _____ to _____

_____
Parent/Legal Guardian's Signature Date

_____
Printed Name of Parent/Legal Guardian Staff Witness/Signature and Date

Phone number where parent/legal guardian can be reached to confirm this letter: _____

Drivers license verified by: _____