**Community Pediatric Care**
782 North Medical Center Drive East, Suite 309
Clovis, California 93611
Office: (559) 387-2150 | Fax: (559) 387-2155

COMMUNITY HEALTH PARTNERS

# Pediatric Health History Questionnaire

| Name: | | | Date: |
|---|---|---|---|
| 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 have or ever had the following:***

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

## PATIENT SURGICAL HISTORY

***Please check if you have or ever had the following:***

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

# Consent for Medical Treatment

**This form gives permission 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: _____