South Shore Medical Center

DEPARTMENT OF PEDIATRICS
PATIENT HISTORY FORM

Patient Label

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

Name	Date of Birth	E-mail Address:
PCP	Date of Visit	Would you like to receive information about *MyChart Online*? ❑ Yes ❑ No

Race/Ethnicity:	❑ White, Non-Hispanic ❑ Black, Non-Hispanic ❑Hispanic ❑Asian ❑ Native American ❑ Native Hawaiian and Other Pacific Islander ❑ Other:
Do you currently live in a shelter or have no steady place to sleep at night? ❑ Yes ❑No	
Current Health Concerns:	

PAST MEDICAL HISTORY						
Birth hospital:	Pregnancy problems?	❑ N	❑ Y	Problem in the nursery?	❑ N	❑ Y
Birth weight:	Labor/Delivery problems?	❑ N	❑ Y	Did baby go home with mom?	❑ N	❑ Y
Discharge weight:	---- with mother?	❑ N	❑ Y	Was baby breast fed?	❑ N	❑ Y
Discharge date:	---- with baby?	❑ N	❑ Y	How long ?		
Pregnancy duration:						
Problems in the 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	❑ 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		
Parent first name:	Age:	Occupation:
Parent first name	Age:	Occupation:
Parents married? ❑ Yes ❑ No	Parents living together? ❑ Yes ❑ No	
Child's daytime caregiver?		
Others living in your home?		
Siblings names, gender and ages:		

Form ID: PHF1

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FAMILY HISTORY

Please check if there is a family history of the medical problems noted below.

(both parents, siblings, grandparents, aunts, uncles and cousins)

❑ Check here if Family History is unknown

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
❑ Asthma		❑ M ❑ P	❑ Kidney		❑ M ❑ P
❑ Birth Defects		❑ 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
❑ Development		❑ M ❑ P	❑ Stomach/Bowel		❑ M ❑ P
❑ Diabetes		❑ M ❑ P	❑ Thyroid		❑ M ❑ P
❑ Drug Abuse		❑ M ❑ P			
Any other medical condition "that runs in the family"?					

DEVELOPMENT/BEHAVIOR					
Problems with eating?	❑ N	❑ Y	Problems in school?	❑ N	❑ Y
Problems with sleeping?	❑ N	❑ Y	Problems with peers/siblings?	❑ N	❑ Y
Problems with elimination?	❑ N	❑ Y	Problems with behavior?	❑ N	❑ Y
Problems with temper?	❑ N	❑ Y	Problems with toilet training?	❑ N	❑ Y
At what age did your child sit alone?			At what age did your child speak words?		
At what age did your child walk?					
Do you have any concerns about your child's development?					

SAFETY/ENVIRONMENT					
Does your child always wear a seat belt?	❑ N	❑ Y	Are there any smokers at home?	❑ N	❑ Y
Does your child always wear a helmet?	❑ N	❑ Y	Does your home contain lead paint?	❑ N	❑ Y
Do you have working smoke detectors?	❑ N	❑ Y	Do you have any firearms in the house?	❑ N	❑ Y
Do you have carbon monoxide detector?	❑ N	❑ Y	If yes, is ammunition stored separately?	❑ N	❑ Y

TUBERCULOSIS SCREEN		
Has your child lived with or spent time with anyone who was positive for tuberculosis?	❑ N	❑ Y
Has your child lived or spent time with anyone who has a positive skin test for tuberculosis?	❑ N	❑ Y
Has anyone in your household come to the United States from another country?	❑ N	❑ Y
Has your child lived with or spent time with adults who were homeless, lived in a shelter?	❑ N	❑ Y
Has your child lived with or spent time with adults who have AIDS or are infected with HIV?	❑ N	❑ Y
Has your child lived with or spent time with adults who used intravenous drugs or other street drugs?	❑ N	❑ Y
Has your child lived with or spent time with adults who lived in a correctional facility, nursing home, or mental institution?	❑ N	❑ Y
If your child has had a positive skin test for tuberculosis in the past, inform your child's health care provider. Your child will not need another test.		

PARENT: Below is information required by the State ***PLEASE CHECK ONE***
❑ Has health insurance and is not Native American (American Indian) or Alaskan Native
❑ This child is enrolled in Medicaid (includes Mass Health and HMO's, etc, if enrolled through Medicaid)
❑ Does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan.)
❑ Is Native American (American Indian) or Alaskan Native

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD

♦ *Thank you for helping us take better care of your child.* ♦

FOR OFFICE USE ONLY.			
Reviewed by:		Date:	