Ivinson Memorial Hospital
MEDICAL GROUP

Pediatric Patient Paperwork

Child Information

Child's Name: _____
LAST FIRST M.I.

Preferred Name:_____ Date of Birth: _____/_____/_____ Age: _____

Sex: Male ☐ Female ☐ Previous Doctor: _____

Parent/Guardian Info

Parent/Guardian Name:_____
LAST FIRST M.I.

Employer:_____ Occupation: _____

Parent/Guardian Name:_____
LAST FIRST M.I.

Employer:_____ Occupation: _____

Current Medications

MEDICATION	DOSE	HOW OFTEN

Does your child take any alternative or herbal medications? *Yes No

*If yes, please list_____

Allergies

MEDICATION	REACTION

Does your child have any other allergies (latex, iodine, food or environment)?

_____

_____

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Birth History

Only needs to be completed if the child is under 3 years of age

Delivery Type: Vaginal *Cesarean

*Why: _____

Birth Weight: _____ Was your child premature? *Yes No *If yes, how many weeks _____

Were there any problems with your child's delivery? *Yes No *If yes, please list:_____

_____

Did your child have any unusual problems in the hospital such as oxygen, transfusions, or phototherapy for jaundice? *Yes No *If yes, please list: _____

_____

Medical History

Any hospitalizations other than birth? *Yes No *If yes, please explain: _____

_____

Any chronic illnesses? *Yes No *If yes, please explain: _____

_____

Has your child seen a specialist? *Yes No

*If yes, please provide name and date of the most recent visit: _____

_____

Review of Systems

System	Yes	No	Explanation of any problems
Lungs			
Heart			
Kidney/Urinary			
Bone/Muscle			
Gastrointestinal			
Brain/Nervous			
Genital			
Skin			
Ear/Nose/Throat			
Developmental concerns or learning problems			
Behavioral problems or eating disorders			
If female: age of first menstrual period			Age:

Ivinson MEMORIAL HOSPITAL
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Surgical History

Has your child had any surgeries? *Yes No *Please list surgery and approximate date:

_____

Social History

Any special communication needs? Yes No

Primary language other than English? Yes No

Child's primary language_____ Parent/Guardian(s)'s primary language_____

**Language line is available to help us better communicate if English is not your first language. Please let the nurse know if you would like to use the language line.*

Parents: Married Separated Divorced Single

How many people live in your home? _____Adults _____ Children

Are there smokers in the home? Yes No
Any pets at home? *Yes No *If yes, please list: _____

_____

Are there smoke detectors in your home? Yes No
Are there carbon monoxide detectors in your home? Yes No
Does your child attend: Daycare Preschool Grade K-12
What school? _____

Sibling's Name	Date of Birth
1.	
2.	
3.	
4.	

Family History

List any medical conditions of the child's family members listed below:	
Mother	
Father	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Siblings	
Other Relatives (Aunt, Uncle, Cousin, etc.)	