Midtown Clinic – Pediatric Health History Form

1944 Allen Ct, Ste A ● Juneau, AK 99801 ● Phone (907) 463-6882 ● Fax (907) 463-6888

PATIENT INFORMATION

PATIENT'S NAME ____ DATE OF BIRTH __________________
(first) (middle) (last)

PREFERRED NAME ____

PHYSICAL ADDRESS ____
(street) (city) (state) (zip code)

MAILING ADDRESS ____
(street) (city) (state) (zip code)

SOCIAL SECURITY NUMBER _________________________ PRIMARY PHONE ______________________________

RACE (select all that apply)
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race
- ☐ Choose not to disclose

ETHNICITY (select one)
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Choose not to disclose

SEXUAL ORIENTATION (select one)
- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

GENDER IDENTITY (select one)
- ☐ Female
- ☐ Male
- ☐ Transgender Female (male to female)
- ☐ Transgender Male (female to male)
- ☐ Something else
- ☐ Choose not to disclose

GENDER AT BIRTH (select one)
- ☐ Female
- ☐ Male

Is the patient best served in a language other than English? ☐ No ☐ Yes If yes, what language? _______________

Has the patient ever had a case with the Office of Children's Services? ☐ No ☐ Yes

GUARDIAN INFORMATION

GUARDIAN'S NAME ____
(first) (middle) (last)

PHYSICAL ADDRESS ____
(street) (city) (state) (zip code)

MAILING ADDRESS ____
(street) (city) (state) (zip code)

PHONE ________________________ ☐ Home ☐ Work ☐ Cell RELATIONSHIP TO PATIENT ________________

EMAIL ADDRESS ____

GUARDIAN'S NAME ____
(first) (middle) (last)

PHYSICAL ADDRESS ____
(street) (city) (state) (zip code)

MAILING ADDRESS ____
(street) (city) (state) (zip code)

PHONE ______________________ ☐ Home ☐ Work ☐ Cell RELATIONSHIP TO PATIENT ________________

EMAIL ADDRESS ____

EMERGENCY CONTACT

NAME ______________________________________ RELATIONSHIP TO PATIENT ______________________

PHONE ____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Company ______________________________

Member/Policy ID # ______________________________

Group # ______________________________

Subscriber Name ______________________________

Date of Birth ______________________________

SSN ______________________________

Relationship to Patient ______________________________

SECONDARY INSURANCE
Insurance Company ______________________________

Member/Policy ID # ______________________________

Group # ______________________________

Subscriber Name ______________________________

Date of Birth ______________________________

SSN ______________________________

Relationship to Patient ______________________________

HOUSEHOLD INCOME ________________________ monthly/annually TOTAL # OF PEOPLE IN HOUSEHOLD ________

FAMILY PROFILE			
Who lives in your home? (please include yourself and any significant others)			
Name	Birth Year	Relationship to Patient	Occupation

Are there any smokers in the house? ☐ No ☐ Yes If yes, do they smoke ☐ tobacco ☐ marijuana

Are there any pets in the house? ☐ No ☐ Yes If yes, what type and how many?

Current housing situation ☐ Single family home ☐ Apartment/Condo ☐ Group home ☐ Shelter ☐ Couch Surfing ☐ Other

Utilities available in current housing ☐ Electricity ☐ Running Water ☐ Internet ☐ Telephone ☐ Heat

Are there any cultural or religious beliefs that may affect healthcare choices? ☐ No ☐ Yes

If yes, please explain: ____

FAMILY HEALTH HISTORY

Please let us know who in the patient's family has any of the conditions listed below.

☐ History is unknown – the patient is adopted or in foster care.

Paternal Codes	Dad (DAD) Grandfather (PGF) Grandmother (PGM)	**Maternal Codes**	Mom (MOM) Grandfather (MGF) Grandmother (MGM)	**Sibling Codes**	Brother (BRO) Sister (SIS)

Condition	**Who** DAD	PGF	PGM	MOM	MGF	MGM	BRO	SIS
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disorders (Anemia, Sickle Cell, Hemophilia)	☐	☐	☐	☐	☐	☐	☐	☐
Bone Problems	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (Specify what type ____________________________)	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Digestive or Intestinal Problems (Specify ________________)	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Problems	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Joint Problems	☐	☐	☐	☐	☐	☐	☐	☐
Kidney or Bladder Problems	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities or Challenges	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health (ex. depression, anxiety, schizophrenia)	☐	☐	☐	☐	☐	☐	☐	☐
Seizures or Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse (drugs or alcohol)	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems / Autoimmune Conditions	☐	☐	☐	☐	☐	☐	☐	☐

Other ____	☐	☐	☐	☐	☐	☐	☐	☐

PATIENT HEALTH HISTORY	
Delivery Method ☐ Vaginal Birth ☐ Cesarean Born at _______________ weeks	
Birth Place ☐ Hospital ☐ Birth Center ☐ Home Birth ☐ Other ______________________________________	
Birth Length _____________________ Birth Weight _____________________ Feeding ☐ Breastfed ☐ Formula	
Problems During Newborn Stage? ☐ No ☐ Yes If yes, explain ____	
What age did your child sit alone?	What age did your child crawl?
What age did your child walk alone?	What age did your child say specific words?
For Children Under 5 Years Old	
What style car seat are you currently using? ☐ Rear facing ☐ Forward facing ☐ Booster Seat ☐ None	
Is the child in childcare? ☐ No ☐ Yes If yes, what type? ☐ Daycare Facility ☐ In-Home Daycare ☐ Family ☐ Other	
Does the child participate or have they participated in the infant learning program at REACH? ☐ No ☐ Yes	
Does the child participate in the Juneau School District Integrated Preschool Program? ☐ No ☐ Yes	
For Children Over 5 Years Old	
What grade is the child currently in and what school do they attend? Grade ________ School ___________________	
How would you describe their performance in school? ☐ No Problems ☐ Academic Difficulties ☐ Social Issues ☐ Behavioral Concerns	
For Children Ages 9 and Up	
Age of puberty onset:	*Females:* Age of menstrual cycle onset:

ALL AGES: please circle any problems that your child has been diagnosed with			
ADHD	Cancer	Hearing Loss	Migraines
Acne	Chicken Pox	Heart Disease	Seasonal Allergies
Anemia	Chronic Constipation	High Blood Pressure	Seizure
Anxiety	Depression	High Cholesterol	Sexual Transmitted Disease
Asthma	Diabetes	Incontinence	Skin Problems
Autoimmune Disease	Eczema	(Inherited) Metabolic Disease	Tuberculosis or +TB Test
Behavioral Problems	Frequent Ear Infection	Insomnia	Urinary Tract Infections
Birth Defects	Food Allergies	Kidney Disease	Warts
Bleeding or Clotting Disorders	Gastrointestinal Problems	Learning Difficulties	Weight Concern
Bone and Joint Disease	Headaches	Mental Illness	Vision Problems
Broken Bone(s)	Head Injury or Concussion	Menstrual Problems	Other ______________________

CURRENT AND PRIOR PRIMARY AND SPECIALTY CARE MEDICAL PROVIDERS		
Provider	Location	Contact Number

SURGERIES & HOSPITALIZATIONS		
☐ No Surgical or Hospitalization History		
Year	Reason	Hospital

ALLERGIES TO MEDICATIONS	
☐ No Known Allergies	
Medication Name	Reaction (ex. hives, rash, wheezing, facial swelling)

ALLERGIES TO FOODS/OTHER	
☐ No Known Allergies	
Foods/Other Name	Reaction (ex. hives, rash, wheezing, facial swelling)

CURRENT MEDICATIONS, VITAMINS & SUPPLEMENTS		
☐ No Current Medications ☐ No Current Vitamins or Supplements		
Medication/Vitamin/Supplement Name	Dosage	Frequency

PLEASE LIST ANY OTHER CONCERNS HERE

I CERTIFY THAT I HAVE READ ALL INFORMATION ON THIS FORM AND HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. I CONSENT TO TREATMENT, INCLUDING DIAGNOSTIC PROCEDURES, EXAMINATIONS, AND TREATMENT THAT THE PHYSICIAN DESIGNATES AND CONSIDERS TO BE NECESSARY TO TREAT MY CHILD'S CONDITION.

LEGAL GUARDIAN SIGNATURE ____ DATE __________________________