***Please provide our office staff with your insurance card and photo ID so that we may scan into our system.**

Patient Name: _____ Sex: _____ Date of Birth: _____

Home Address: _____

Home #: _____ Cell #: _____ Social Security #: _____

Pharmacy Name: _____ Location: _____

How did you hear about Community Quick Care? _____

GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Mother's Email Address: _____ Mother's SSN: _____

Father's Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Father's Email Address: _____ Father's SSN: _____

Other Guardian Info: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Second Insurance Company: _____ ID #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Patient Name: _____ Sex: _____ Date of Birth: _____

AUTHORIZATION TO PRESENT CHILD TO OFFICE

As guardian, I authorize these individuals to present patient to office for medical care until changed in writing:

Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____

VERBAL CONSENT

As guardian, I authorize these individuals to receive verbal information or speak to office staff on behalf of patient:

Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Home Address: _____

Your signature on this form authorized us to receive payment and release medical information to your health insurance company. All other releases of medical records require additional authorization. Should our office have a need to leave a message on your cell concerning your appointment, your signature on this form gives us that permission. Your signature also indicates that you have received a copy of the HIPPA regulations (if requested), and you are giving us consent to treat you for your medical conditions.

_____ _____

GUARDIAN'S SIGNATURE **DATE**

Pediatric History Questionnaire

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____ M / F_____

Household

Please list all those living in child's home:

Name	Relationship to child	Birthdate	Health Problems

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

_

Birth History

Birth weight _____
Was the baby born full term? _____ Early? _____ Late? _____
If early, how many weeks' gestation? _____
Did mother have any illness or problems with her pregnancy?
Yes _____ No _____ Explain _____
_____
_____
During pregnancy, did mother smoke? Yes _____ No _____
Drink alcohol? Yes _____ No _____
Use drugs or medications? Yes _____ No _____
Explain _____

Delivery was: Vaginal _____ Cesarean _____
If cesarean, why? _____
Did your baby have any problems right after birth?
Yes _____ No _____ Explain _____

Initial feeding was: Breast _____ Bottle _____
Did your baby go home with mother from the hospital?
Yes _____ No _____ Explain _____
_____
_____

Medications

Please list all medications below:

Name of medication	Dosage	Frequency	Reason for Medication

Pediatric History (continued): General

Do you consider yourself to be in good health? _____ Yes _____ No Explain: _____
Do you have a serious illness or medical condition? _____ Yes _____ No Explain: _____
Have you had any serious injuries or accidents? _____ Yes _____ No Explain: _____
Have you had any surgeries? _____ Yes _____ No Explain: _____
Have you ever been hospitalized? _____ Yes _____ No Explain: _____
Are you allergic to any medicines or drugs? _____ Yes _____ No Explain: _____

Family History

Have any family members had the following:

Deafness:	_____ Yes	_____ No	Who _____	Comments _____
Nasal Allergies	_____ Yes	_____ No	Who _____	Comments _____
Asthma	_____ Yes	_____ No	Who _____	Comments _____
Tuberculosis	_____ Yes	_____ No	Who _____	Comments _____
Heart Disease (before 50 years old)	_____ Yes	_____ No	Who _____	Comments _____
High Blood Pressure (before 50 years old)	_____ Yes	_____ No	Who _____	Comments _____
High Cholesterol	_____ Yes	_____ No	Who _____	Comments _____
Anemia	_____ Yes	_____ No	Who _____	Comments _____
Bleeding disorder	_____ Yes	_____ No	Who _____	Comments _____
Liver Disease	_____ Yes	_____ No	Who _____	Comments _____
Kidney Disease	_____ Yes	_____ No	Who _____	Comments _____
Diabetes (before 50 years old)	_____ Yes	_____ No	Who _____	Comments _____
Epilepsy or convulsions	_____ Yes	_____ No	Who _____	Comments _____
Alcohol abuse	_____ Yes	_____ No	Who _____	Comments _____
Drug Abuse	_____ Yes	_____ No	Who _____	Comments _____
Mental Illness	_____ Yes	_____ No	Who _____	Comments _____
Mental Retardation	_____ Yes	_____ No	Who _____	Comments _____
Immune Problems, HIV, or AIDS	_____ Yes	_____ No	Who _____	Comments _____
Cancer	_____ Yes	_____ No	Who _____	Comments _____
Sickle Cell Disease	_____ Yes	_____ No	Who _____	Comments _____

Additional family history _____

_____

Past History

Does your child have, or has he/she ever had:

Chickenpox	_____ Yes	_____ No	When _____
Frequent ear infections	_____ Yes	_____ No	Explain _____
Problems with ears or hearing	_____ Yes	_____ No	Explain _____
Nasal allergies	_____ Yes	_____ No	Explain _____
Problems with eyes or vision	_____ Yes	_____ No	Explain _____
Asthma, bronchitis, or pneumonia	_____ Yes	_____ No	Explain _____
Any heart problem or heart murmur	_____ Yes	_____ No	Explain _____
Anemia or bleeding problem	_____ Yes	_____ No	Explain _____
Blood transfusion	_____ Yes	_____ No	Explain _____
Frequent abdominal pain	_____ Yes	_____ No	Explain _____
Constipation requiring doctors visits	_____ Yes	_____ No	Explain _____
Bladder or kidney infection	_____ Yes	_____ No	Explain _____
Bed-wetting (after 5 years old)	_____ Yes	_____ No	Explain _____
(For girls) Has she started her menstrual period?	_____ Yes	_____ No	When _____
Any chronic or recurrent skin problem (acne, eczema, etc.)	_____ Yes	_____ No	Explain _____
Frequent headaches	_____ Yes	_____ No	Explain _____
Convulsions or other neurologic problem	_____ Yes	_____ No	Explain _____
Diabetes	_____ Yes	_____ No	Explain _____
Thyroid or other endocrine problem	_____ Yes	_____ No	Explain _____
Any other significant problem	_____ Yes	_____ No	Explain _____
Use of alcohol or drugs	_____ Yes	_____ No	Explain _____

Family and Social History

Patient Name: _____ **DOB:** _____

Please circle one for each family member:

Father	Alive	Deceased	Unknown	
Mother	Alive	Deceased	Unknown	
Siblings	Alive	Deceased	Unknown	N/A
Paternal Grandfather	Alive	Deceased	Unknown	
Paternal Grandmother	Alive	Deceased	Unknown	
Maternal Grandfather	Alive	Deceased	Unknown	
Maternal Grandmother	Alive	Deceased	Unknown	

Please circle only one per line:

Patient's Parents	Single	Married		
Daycare	Yes	No		
Guns in Home	Yes	No		
Water in home	Bottled water	City Water	Well water	Spring Water
Family Smoking	Yes	No	Details: _____	
Pets at Home	Indoors	Outdoors	None at Home	
Home Type	Mobile home	Apartment	House	Duplex
Home Heat Type	Forced Air	Baseboards		
Home Mold/Mildew	Yes	No		
Patient Alcohol/ Drugs	Yes	No	Details: _____	
Patient Sexually Active	Yes	No		
Patient Traveled outside US	Yes	No	Details: _____	
Patient Occupation	Student:	Part-time	Full-time	
	Employed:	Part-time	Full-time	

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____