Pediatric Healthcare Associates

PRE-VISIT FAMILY FORM

Date: _____

Parent 1: _____
(Last Name) (First Name) (DOB)

Parent 2: _____
(Last Name) (First Name) (DOB)

Address: _____

Phone: (daytime) _____

(evening) _____
(Parent 1) (Parent 2)

Occupation: _____
(Parent 1) (Parent 2)

Referred by: _____

Family History: (check all that apply)

☐ allergies	☐ anemia	☐arthritis	☐ asthma
☐ birth defects	☐ cancer	☐ diabetes	☐ seizures
☐ heart disease	☐ high cholesterol	☐ hypertension	☐ lazy eye
☐ mental illness	☐ migraines	☐ thyroid disease	☐ tuberculosis

Child #1 Name: _____ DOB: _____ Sex: _____

Full term pregnancy ☐ yes ☐ no Birth weight: _____

Any of the following chronic issues: ☐ allergies ☐ frequent ear infections
☐ pneumonia ☐ seizures ☐ asthma or wheezing ☐ urinary tract infections
☐ heart murmur ☐ behavior or school problems

Hospitalizations (dates, reason) _____

Past surgery (dates, reason) _____

Medications: _____

Child #2 Name: _____ DOB: _____ Sex: _____

Full term pregnancy ☐ yes ☐ no Birth weight: _____

Any of the following chronic issues: ☐ allergies ☐ frequent ear infections
☐ pneumonia ☐ seizures ☐ asthma or wheezing ☐ urinary tract infections
☐ heart murmur ☐ behavior or school problems

Hospitalizations (dates, reason) _____

Past surgery (dates, reason) _____

Medications: _____

Child #3 Name: _____ DOB: _____ Sex: _____

Full term pregnancy ☐ yes ☐ no Birth weight: _____

Any of the following chronic issues: ☐ allergies ☐ frequent ear infections
☐ pneumonia ☐ seizures ☐ asthma or wheezing ☐ urinary tract infections
☐ heart murmur ☐ behavior or school problems

Hospitalizations (dates, reason) _____

Past surgery (dates, reason) _____

Medications: _____

Child #4 Name: _____ DOB: _____ Sex: _____

Full term pregnancy ☐ yes ☐ no Birth weight: _____

Any of the following chronic issues: ☐ allergies ☐ frequent ear infections
☐ pneumonia ☐ seizures ☐ asthma or wheezing ☐ urinary tract infections
☐ heart murmur ☐ behavior or school problems

Hospitalizations (dates, reason) _____

Past surgery (dates, reason) _____

Medications: _____