Salem Family Medicine Patient Registration

Please be advised that completing preliminary health insurance questionnaires does not establish a physician-patient relationship with this practice. The doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Patient Name: _____

Address:_____

City: _____ State:_____ Zip:_____

Birth Date:_____ Email: _____

Phone _____Work Phone: _____ Cell Phone: _____

SSN: _____ Pharmacy (& location): _____

Race: _____ Ethnicity: Hispanic Non-Hispanic Language: _____

Emergency Contact:

(Name) _____ (Relationship) _____ (Phone) _____

How did you hear about our clinic? _____

If internet, what site?: _____

Responsible Party:

Name: _____

Address:_____

SSN:_____ DOB:_____

Phone _____

Primary Insurance Plan:

Name: _____ ID# _____ Group # _____

Secondary Insurance Plan:

Name: _____ ID# _____ Group # _____

SALEM FAMILY MEDICINE
PEDIATRIC HEALTH HISTORY FORM

Child's Name: _____ Date: _____

Concerns about your child: _____

_____

_____

Medications (prescriptions & non-rx)**:**

_____

_____

_____

_____

Allergies/reactions to medications/immunizations:

☐ none _____

_____

Previous Primary Care Provider:

_____

Birth & Past Medical History:

Is the child yours by:

__birth __adoption __stepchild __other: _____

Birth weight: _____ length: _____

Please list problems during pregnancy or delivery:

_____

Please list problems during newborn period:

_____

Please list significant medical problems since infancy:

_____

_____

Has your child had: __chickenpox __meningitis __mumps __rubella __measles __tuberculosis (TB)

Please list any hospitalizations or surgeries:

_____

_____

Broken bones or severe sprains: _____

_____

Development: At what age did your child:

walk_____ say words_____

Girls only: age at first menstrual period _____

Health Maintenance:

Are your child's immunizations current? __yes __no

(Please bring your child's shot record to your appt.)

Habits:

Has your child had any unusual feeding or dietary problems? __no __yes

Has your child had any sleep problems? __no __yes

Do you live in a home built before 1972? __no __yes

Do any household members smoke? __no __yes

Has your child been to the dentist? __yes __no

Do you use city water? (City:_____)__yes __no

How may hours per day does your child spend with:

TV_____ computer_____ video games_____

School History:

Does your child attend preschool/school? __no __yes

Any concerns about school performance/relationships?

_____

Please indicate if any **Family Members** have had:
(F-father, M-mother, B-brother, S-sister)

__Alcoholism
__Anesthesia problem
__Asthma
__Autoimmune disorder
__Bleeding problem
__Cancer
__Depression/Mental prob
__Diabetes
__Genetic problem
__Heart disease
__High blood pressure
__High cholesterol
__Kidney disease
__Stroke
__Substance abuse
__Thyroid problem

Other significant problems:

_____

_____

_____

Social History:

Birthplace: _____

Who lives at home? (name, age, relationship)

_____

_____

_____

_____

_____

Are the child's parents __married __unmarried __separated __divorced if divorced, when?_____

Mother's occupation: _____

Father's occupation: _____

Child care: __parents __others: _____

Religious preference: _____

Hobbies/interests: _____

Safety:

Does the child always use:

a bike helmet? __yes __no

a helmet, pads & wrist guards when rollerblading/skateboarding? __yes __no

carseat/seatbelts? __yes __no

a lifejacket around water? __yes __no

sunscreen when in the sun? __yes __no

Is violence at home a concern for you? __no __yes

Is there a gun in your home? __no __yes

If so, is it locked apart from ammunition? __yes __no

Review of Symptoms: Please check any current problems your child is having:

Constitutional
__Fevers/chills/sweats
__Unexplained weight chg
__Excess thirst or urination

Eyes/Ears/Nose/Throat
__Squinting/crossed eyes
__Difficult hearing
__Hay fever/allergies

Heart/Lungs
__Cough/wheeze
__Tires easily with exercise
__Shortness of breath
__Fainting

Gastrointestinal
__Constipation
__Nausea/vomiting/diarrhea

Genitourinary
__Bedwetting
__Pain with urination

Muscle/Joint/ Skin
__Muscle/joint pain
__Rash/mole change
__Unexplained lumps
__Easy bruising/bleeding

Neurological
__Headaches
__Weakness
__Clumsiness
__Speech problems
__Temper/breath holding
__Anxiety/depression

Other:

_____