

Demographics and Insurance Information

Patient's Name:

First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Primary Contact: Home Phone Cell Phone

Email Address: _____ DOB: _____

Gender Male Female Social Security #: _____

Race: White Hispanic Black or African American Asian Decline to Report Other: _____

Ethnicity: Hispanic or Latino/a Not Hispanic or Latino/a Decline to Report Other: _____

Parent/Guardian #1: Name: _____ Relationship to minor: _____

Cell Phone: _____ Date of Birth: _____

Parent/Guardian #2: Name: _____ Relationship to minor: _____

Cell Phone: _____ Date of Birth: _____

Preferred Pharmacy: _____ Phone #: _____

Whom may we call in case of an emergency? Name: _____

Relationship to patient: _____ Primary Phone #: _____

What if my child needs to see a provider? A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment on the account.

Insurance Information

Primary Insurance Company: _____ Insurance Phone #: _____

Subscriber Name: _____ DOB: _____ SS#: _____

Insurance ID: _____ Group #: _____

Patient Relationship to Subscriber: _____

Secondary Insurance Company: _____ Insurance Phone #: _____

Subscriber Name: _____ DOB: _____ SS#: _____

Insurance ID: _____ Group #: _____

Patient Relationship to Subscriber: _____



**Willow Tree
Pediatrics of
Lexington**

PEDIATRIC MEDICAL HISTORY FORM

Patient Name: _____

DOB: ____/____/____

Name of Person Completing Form: _____

Relation to Patient: _____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, etc.*

| Medication Name | Dose | Frequency |
|-----------------|------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

**** If you are on 5 or more medications – please bring them with you to each appointment. ****

ALLERGIES: *List all reactions to medicines, foods and other agents*

| Allergy | Reaction or Side Affect |
|---------|-------------------------|
| | |
| | |

REVIEW OF SYSTEMS: *Please indicate with a check (V) any current or ongoing problems your child has on the list below*

CONSTITUTIONAL

- Fevers/chills/sweats
- Unexplained weight loss
Fatigue/weakness
- Excessive thirst or urination

CARDIOVASCULAR

- Chest pain/discomfort
- Leg pain with exercise
- Palpitations

GASTROINTESTINAL

- Abdominal pain
- Blood in bowel movement
- Nausea/vomiting/diarrhea

NEUROLOGICAL

- Headaches
- Dizziness/light-headedness
- Numbness
- Memory loss
- Loss of coordination

EYES

- Change in vision
- Nearsighted
- Farsighted

GENITOURINARY

- Nighttime urination
- Incontinence
- Discharge from penis

GYNECOLOGICAL

- Abnormal vaginal bleeding
 Vaginal discharge
 Vaginal odor

EARS/NOSE/THROAT/MOUTH

- Difficulty hearing/ringing in
 Hay fever/allergies
 Problems with teeth/gums

RESPIRATORY

- Cough/wheeze
 Difficulty breathing

MUSCULO-SKELETAL

- Muscle/joint pain

SKIN

- Rash or mole change(s)

PSYCHIATRIC

- Anxiety/stress
 Problems with sleep
 Depression
 ADHD

OTHER: _____

HOSPITALIZATIONS: *Please list all prior hospitalizations and dates.*

| Reason | Hospital / Clinic Name | Date |
|--------|------------------------|------|
| | | |
| | | |

SURGERIES: *Please list any surgeries, location, and dates.*

| Surgery | Hospital / Clinic Name | Date |
|---------|------------------------|------|
| | | |
| | | |

PREGNANCY & BIRTH:

Is the patient yours by: Birth Adoption Stepchild Other: _____

Were there any medical problems during pregnancy? Yes No If yes, please explain: _____

Were there problems during labor and delivery? Yes No If yes, please explain: _____

Were there problems such as needing oxygen, trouble breathing, jaundice (yellowness), after the patient's birth? Yes No

If yes, please explain: _____

Where was the patient born? _____ Method of Delivery: Vaginal Cesarean Birth

Weight/Length: ____ lbs. ____ oz. ____ inches Was your child born prematurely? Yes No If yes how early: _____

For Male Patients Only: Is your child circumcised? Yes No

SLEEP:

How many hours a night does the patient sleep? _____

How many naps does the patient take per day and length of naps? _____

Does the patient have any sleep problems? Yes No If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding when the patient was a newborn: Breastfed Formula. If breastfed, for how long? _____

Has the patient had any feeding/dietary problems or restrictions? Yes No If yes, please explain: _____

Milk intake now: Soy Milk Rice Milk Cow's Milk (____ %) other, please specify: _____

of ounces of milk per day _____

Has the patient seen a dentist? Yes No If yes, date of last visit _____

What is the water source at the house? City Well