Willow Tree Pediatrics of Lexington
2036 Regency Road, Ste 2 Lexington, KY 40503
859-286-9046

DEMOGRAPHICS AND INSURANCE

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.

_____

Insurance Information

Please list ALL insurance information and plans the parent/guardian has had within the last calendar year.

Insurance Company:_____ **Insurance Phone #**:_____

Subscriber Name:_____ DOB:_____ SS#:_____

Insurance ID:_____ Group #:_____

Patient Relationship to Subscriber:_____

Insurance Company:_____ **Insurance Phone #**:_____

Subscriber Name:_____ DOB:_____ SS#:_____

Insurance ID:_____ Group #:_____

Patient Relationship to Subscriber:_____

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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 (√) 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