



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