Dignity Health
Woodland Healthcare

NAME: ______
DOB: ______
MRN: ______

Thank you for choosing Woodland Healthcare Pediatrics!

What brings you in today? ___ Moved ___ Insurance change ___ Change in caregiver

Please tell us about your child's prior health care: ☐ Patient is a newborn, N/A

Doctor's name: ______ City, State: ______

Clinic/Organization: ______

Medical Records:

Do you have any medical records with you today? ___ Yes ___ No

Do you plan to have your medical records sent to us? ___ Yes* ___ No

*If yes, please ask the receptionist for a Release of Information Form

Immunizations:

Has your child received any immunizations? ___ Yes ___ No

Does your child have an immunization record or list? ___ Yes* ___ No

*If yes, do you have the record with you today? ___ Yes ___ No

How old was your child when he/she was last immunized? ______

Allergies:

Allergies: ___ Certain Foods ___ Insect Bites ___ Animals ___ Seasonal ___ Certain Medications

Medications: Please list all medications your child is currently taking on a regular basis:

______

Please list all non-perscription medications that your child is taking:

______

Medical History:

Where was your child born? City, State: ______

If other than within the United States, what was the date of immigration? ______

Has your child ever had any of the following? If yes, please indicate if this is a current issue.

	YES	NO	CURRENTLY
1. Frequent ear infections			
2. Wheezing, coughing, pneumonia			
3. Heart murmur or problem			
4. Skin problems			
5. Frequent headaches			
6. Eye sight problems			
7. Hearing problems			
8. Dental problems			
9. Weight problems (loss or gain)			
10. Frequent constipation or diarrhea			
11. Frequent stomach aches			
12. Problems with urination			
13. Bed-wetting			
14. Joint pain or swelling			
15. Swollen glands			
16. Anemia			
17. Lead exposure			
18. Loss of consciousness			
19. Behavioral or developmental problems			

Has your child ever been hospitalized? ______ ______ Explain: ______

Has your child ever had surgery? ______ ______ Explain: ______

Please continue on the reverse side…

Office Use Only

MRN:

Family History:

Who lives in the child's home? ___ Mother ___ Father ___ Stepmom ___ Stepdad
___ Guardian ___ Adoptive Parents ___ Grandma ___ Grandpa ___ Other: ____________________
___ Brothers (ages: ________________) ___ Sisters (ages: _______________)

Parents'/Guardians' Occupations:

Parent #1: ____

Parent #2: ____

Has the child been exposed to any of the following:

___ Domestic Violence ___ Sexual Abuse ___ Physical Abuse ___ Neglect ☐ None

Family Medical History:

Have any members of the family had any of the following problems? Please include parents, grandparents, aunts, uncles, brothers and sisters.

	YES	NO	Relationship to the child
1. Blindness			
2. Birth Defect (Type: ___________________)			
3. Mental Retardation			
4. Seizures/epilepsy			
5. Deafness			
6. Migraine headaches			
7. Tuberculosis			
8. Asthma			
9. Eczema/Hay Fever			
10. Anemia/blood disorder			
11. High blood pressure			
12. High cholesterol			
13. Heart attack or stroke under age 55			
14. Diabetes			
15. Arthritis/Autoimmune Disorder			
16. Cancer (Type: _______________________)			
17. Depression/Mental Health			
18. Alcoholism/Drug Problem			
19. Other: ______________________________			

Newborn Section: ***(To be completed for all new patients up to 4 months of age)***

Birth weight: _____ lbs _____ oz ___ Vaginal Birth ___ Cesarean Section

Was the baby born: ___ Term - or - ___ Premature at: ______ weeks

Did mother have routine prenatal care? ___ Yes ___ No

Any pregnancy complications? ___ No ___ Yes: ____

Was there maternal use/exposure of any of the following during pregnancy:

___ Alcohol ___ Cigarettes ___ Marijuana ___ Other Drugs

Any problems soon after birth? (Ex: Jaundice, NICU stay, Infection) ______________________________________