PEDIATRIC AND ADOLESCENT ADVANCED CARE, PLLC

DEMOGRAPHICS

Name: _____ **Alias:** _____
Date of birth: _____/_____/_____ **Sex:** _____ **Home Phone:** _____-_____-_____
SSN: _____/____/_____ **Address:** _____ **City, State, Zip:** _____
Temporary Address: _____
Email: _____ **Language:** _____ **Need Interpreter:** Yes/No
Ethnic group: (Please select one): Hispanic Non-Hispanic Other: (Please Specify)_____
Patient Race: _____

MyChart Access: MyChart is a patient portal that allows patients to obtain access to their medical history and patient chart from home. It is utilized within our office as well as a multitude of Hospitals we now provide this service to our patients. More information is available upon request.
Would you like to register for MyChart? Yes No

EMERGENCY CONTACTS

Name: _____ **Relationship to patient:** _____
Home Phone: ____-_____-_____ **Mobile Phone:** ____-_____-_____ Work **Phone:** ____-____-_____
Legal Guardian: Yes / No **Address:** _____ **City, State, Zip:** _____
Impaired: Hearing / Visual / None **Notify on Admission:** Yes / No **Comments:** _____

Name: _____ **Relationship to patient:** _____
Home Phone: ____-_____-_____ **Mobile Phone:** ____-_____-_____ Work **Phone:** ____-____-_____
Legal Guardian: Yes / No **Address:** _____ **City, State, Zip:** _____
Impaired: Hearing / Visual / None **Notify on Admission:** Yes / No **Comments:** _____

GUARANTOR INFORMATION *(Responsible Party/ Self if patient is 18+years)*

Name: _____ **Relationship to patient:** _____

Date of birth: _____/_____/_____ **Sex:** _____ **Account type:** _____

SSN: _____/____/_____ **Address:** _____ **City, State, Zip:** _____

Home Phone: ____-_____-_____ **Mobile Phone:** ____-_____-_____ **Work Phone:** ____-____-_____

Employer: _____ **Employment Status:** _____ **Location:** _____

(Significant other)Name: _____ **Date of birth:** ____/____/_____ **SSN:** ____/___/_____

Primary Insurance: _____ **Policy Holder:** _____

Signature: _____ **Date:** ____/____/_____

SOCIAL HISTORY

	Who does the patient live with? NAME	BIOLOGICAL RELATION?	AGE
Parents:		Y / N	
		Y / N	
Siblings:		Y / N	
		Y / N	
		Y / N	
		Y / N	
Other:		Y / N	
		Y / N	

Best way for patient or parent to learn:

☐ Read ☐ Practice ☐ Group Discussion ☐ One on one
☐ Listen ☐ Video/TV ☐ See demonstration ☐ All

Does anyone smoke in the home? Yes / No **Does the patient:** Smoke / Use Recreational Drugs Alcohol *(amount)*

Immunizations up to date: Yes No Unsure

Patients Last Menstrual Period (If applicable): ____/____/_____ **Age of onset:** _____

Have any of the following tests been performed on the patient? (Please circle)

Ultrasound MRI CT UGI Hida Scan Swallow Study PH Probe Labs Other:_____

Were the results: NORMAL or ABNORMAL **Location of test: _____**

Have you seen any other specialists: _____

Do you have any allergies? Please list all known allergies.

_____ Reaction: _____

_____ Reaction: _____

Pharmacy Name: _____

Pharmacy Address: _____ **Phone Number**: _____

Are you on any medications (including over the counter medications)?

Name of Medication:	Dosage	Times Given
_____	_____	_____
_____	_____	_____
_____	_____	_____

BIRTH HISTORY

Birth Weight: _____ **Delivery:** Vaginal or C-Section
Was your child born (please circle):
Full Term or Premature

If premature, what was the gestational age?
_____

NICU Stay? Yes No If Yes, How Long?
_____

How long on ventilator?
_____

How soon after birth did your child have a bowel movement?
_____

Reason for C-Section (please circle):
Repeat Fetal Distress Failure to progress
Emergency Breech
Other:
_____

BIRTH COMPLICATIONS					
	Yes	No		Yes	No
Apnea			Imperforate Anus		
Chronic Lung Disease			Gastroschisis		
Neonatal Infection			Omphalocele		
Prenatal Drug Exposure			Undescended testicle at birth		
Brain Bleed			Seizure **(as a newborn Only)**		
Hydrocephalus or Enlarged Ventricles			Meconium Aspiration		
Severe Jaundice requiring blood transfusion			Multiple Birth How Many: _____ Surviving: _____		
Feeding Difficulties			Other:		

FAMILY MEDICAL HISTORY

Family Member	**Please list all medical conditions.**
Mother	
Maternal Grandmother	
Maternal Grandfather	
Maternal Aunt	
Maternal Uncle	
Father	
Paternal Grandmother	
Paternal Grandfather	
Paternal Aunt	
Paternal Uncle	
Sisters	
Brothers	
Other:	

SURGICAL HISTORY

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Adenoidectomy				**Fracture Surgery**				**ROP Surgery**			
Appendectomy				**Fundoplication**				**Gallbladder**			
Gastrostomy				**Tonsillectomy**				**Circumcision**			
Heart Surgery				**Tracheostomy**				**Cleft Lip**			
Hip Surgery				**Ear Tubes**				**Cleft Palate**			
Inguinal Hernia				**Umbilical Hernia**				**Cosmetic**			
Lymph node				**Dental/Restoration**				**PDA Repair**			
VP Shunt				**Orchiopexy**				**Rectal Biopsy**			
Abdominal:____ _____				**Other:**							

PATIENT MEDICAL HISTORY (Alphabetical)

Diagnosis	Child	
	No	Yes
Anemia		
Asthma		
Attention Deficit Disorder (ADD/ADHD)		
Autism/Asperger/Autistic Spectrum		
Behavioral: Bipolar Disorder/ Anxiety/Depression/OCD		
Bleeding Disorders		
Blindness/ Visual Impairment		
Cancer		
Cerebral palsy		
Cystic Fibrosis/Urinary Disorders (Specify)		
Deafness/Hearing Impairment		
Developmental Delay : Learning/Speech/Motor/Cognitive/Speech delay		
Diabetes		
Failure to Thrive		
Febrile Seizure		
Gallstones		
GERD (Gastrointestinal Reflux Disease)		
Heart Disease: Cardiac Defect or Murmur		
Kidney Disease		
Known Genetic Disorder:		
Liver Disease		
Lymph Node Disorder		
Microcephaly (small head)		
Migraine Headaches		
Muscle disorder/dystrophy		
Scoliosis		
Seizure/ Epilepsy		
Sickle Cell Disease or Trait		
Sleep Apnea		
Thyroid Disorders		
Tuberous Sclerosis		
Other Illness/Serious Injuries: _____		