HVMG PRIMARY CARE – ELLWOOD CITY Today's Date: _____

Patient Name: _____ Age: _____ Birthdate: _____

Name of Person Completing this paperwork: _____

Relationship to Child: _____

Immunizations are Up-to-Date? Y / N
*Immunization Records have been forwarded to our office from previous physician and/or school records. Y / N

MEDICAL HISTORY:

Allergies [ ] None / **Allergic to latex**: [ ] Yes [ ] No / **Allergic to contrast dye**: [ ] Yes [ ] No

List current allergies to medications:

_____

List of significant medical problems, both past and current: [ ] None

_____

List of hospitalizations and approximate dates: [ ] None

_____

List of surgical procedures and approximate dates: [ ] None

_____

List current medications with dosage and frequency (please include over-the-counter vitamins and herbals): [ ] None

_____

BIRTH HISTORY:

Please indicate any medical problems during pregnancy? [ ] None
If Yes, please describe _____
Please indicate any medical problems during delivery? [ ] None
If Yes, please describe _____
Please list any medications taken during the pregnancy. [ ] None

_____
Any drug or alcohol use during pregnancy? [ ] None
If Yes, please describe _____
Delivered by (circle): C-Section / Vaginal
No. of weeks gestation: _____ Birth Weight: _____ Discharge Weight: _____
Breast Fed: _____ Bottle Fed: _____ Both: _____
Any medical problems during the newborn period (birth to Day 5 of age)? _____
Hospital of delivery: _____
Hep B vaccine given at hospital? _____

SOCIAL HISTORY:

Current school: _____Grade Level: _____
School performance level: A's B's C's D's Failing
After-School programs/job (if applicable): _____
Is child in daycare or an in-home caregiver? _____
Does anyone in the home smoke? Y / N
Are there firearms in the home? Y / N

Please complete Page 2*

Do you have a swimming pool? Y / N
How often does the patient exercise? _____/week
Do you have a home smoke detector/alarm? Y / N
How much caffeine does patient drink daily? _____cups
Do you have pets? Y / N

Who lives in your household?

Name	**Relationship**	**DOB**

MEDICAL HISTORY (circle all that apply):

ADD/ADHD	Diabetes	High Blood Pressure
Anemia	Eczema	Liver Disease/Hepatitis
Anxiety	Fainting/Dizziness	Recurrent Ear Infections
Asthma/Wheezing	Headaches	Seizures
Bed Wetting	Hearing Problems	Urinary Tract Infections
Chicken pox	Heartburn	Vision Problems
Change in Bowel Habits	Heart Murmur	Weight Fluctuations
Concussion(s)	Heart Disease	
Depression	Hepatitis C	Other: _____

Young Women:
Date of first menstrual period: _____ date of last menstrual period: _____
Last PAP smear (if applicable): _____
Have you ever have an abnormal PAP [ ] Yes [ ] No
Birth Control: [ ] Yes [ ] No Type: _____

FAMILY HISTORY

	Male or Female	Living Age	Deceased Age	Medical problems or cause of death
Parents				
Siblings				

Do any PARENT or SIBLING of the patient have (circle all that apply):

Hypertension (high blood pressure)	Anemia	Thyroid problems
Heart disease	Asthma	Osteoporosis
Atrial fibrillation (irregular heart beat)	COPD/Emphysema	Seizures
Congestive heart failure	Crohns disease/Ulcerative Colitis	Cancer (what type? _____)
Stroke	Celiac disease (wheat allergy)	
Blood clots	Diabetes	