Quincy Pediatric Associates Inc.
Patient History Form
01/01/2015

Name	Date of Birth	Parent E-mail Address
PCP	Todays Date	Telephone: Home ☐ Cell ☐

Primary Language:	Secondary Language:
Race/Ethnicity:	☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic ☐ Asian ☐ Native American ☐ Native Hawaiian and Other Pacific Islander ☐ Other
Current Health Concerns:	

BIRTH HISTORY (complete only if child is < than 3 years of age)			
Birth Hospital:	Pregnancy Problems:	☐ Yes	☐ No
Birth Weight:	Labor/Delivery Problems:	☐ Yes	☐ No
Discharge Weight:	Problems in the Nursery:	☐ Yes	☐ No
Discharge Date:	Breastfeeding	☐ Yes	☐ No
Pregnancy Duration:	Bottle Feeding	☐ Yes	☐ No

PAST MEDICAL HISTORY
Chronic Illness/Injuries?
Hospitalizations/Surgeries?
Behavior Issues?
School Issues?

ALLERGIES			
Allergic to any medications?	☐ No	☐ Yes	List:
Adverse Reaction to Medications	☐ No	☐ Yes	List:
Allergic to any foods?	☐ No	☐ Yes	List:
Other Allergies?	☐ No	☐ Yes	List:

MEDICATIONS
List all medications you are currently taking including prescription medications, over the counter medications and herbal remedies

SOCIAL HISTORY		
Parent/Guardian#1:	DOB	Occupation:
Parent/Guardian#2:	DOB	Occupation:
Does child live with parents: ☐ Yes ☐ No	Parents Living together ☐ Yes ☐ No	Marital Status ☐ M ☐ S ☐ D
If parents are divorced or not living together, What is the custody status:		
How often does child see parent not living in the home:		
Is child adopted ☐ Yes ☐ No		
Household (All those living in the child's home: names, gender and ages:		
Do you have any pets at home: ☐ Yes ☐ No		
Does anyone smoke at home: ☐ Yes ☐ No		
Do you have any firearms in the home: ☐ Yes ☐ No		

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FAMILY HISTORY
Please check if there is a family history of the medical problems noted below
(mother, father, siblings, grandparents, aunts and uncles)

Problem	Relationship	Maternal/Paternal	Problem	Relationship	Maternal/Paternal
◻ ADD		◻ M ◻ P	◻ GERD (reflux)		◻ M ◻ P
◻ AIDS		◻ M ◻ P	◻ Heart Attack		◻ M ◻ P
◻ Alcohol		◻ M ◻ P	◻ Heart Murmur		◻ M ◻ P
◻ Allergies		◻ M ◻ P	◻ Hepatitis		◻ M ◻ P
◻ Asthma		◻ M ◻ P	◻ High Cholesterol		◻ M ◻ P
◻ Autistic Disorder		◻ M ◻ P	◻ Hypertension		◻ M ◻ P
◻ Birth Defects		◻ M ◻ P	◻ Hyperthyroidism		◻ M ◻ P
◻ Cancer		◻ M ◻ P	◻ Hypothyroidism		◻ M ◻ P
◻ Colitis		◻ M ◻ P	◻ Learning Problem		◻ M ◻ P
◻ Cystic Fibrosis		◻ M ◻ P	◻ Mental Retardation		◻ M ◻ P
◻ Depression		◻ M ◻ P	◻ Migraines		◻ M ◻ P
◻ Diabetes		◻ M ◻ P	◻ Rheumatoid Arthritis		◻ M ◻ P
◻ Drug Abuse		◻ M ◻ P	◻ SIDS		◻ M ◻ P
◻ Eczema		◻ M ◻ P	◻ Tuberculosis		◻ M ◻ P
◻ Epilepsy		◻ M ◻ P	◻ Urinary Problems		◻ M ◻ P

Any other medical conditions "that run in the family"?

SAFETY/ENVIRONMENT

Working Smoke Detectors in home	◻ Yes	◻ No	Does your child always wear a seat belt?	◻ Yes	◻ No
Carbon Monoxide Detectors in home	◻ Yes	◻ No	Does your child use sunscreen	◻ Yes	◻ No
Does your child use car seat/booster seat	◻ Yes	◻ No	Does your child use insect repellant	◻ Yes	◻ No
Does someone in your family know CPR	◻ Yes	◻ No	Does your home contain lead paint	◻ Yes	◻ No

TUBERCULOSIS SCREEN

Has anyone in your household come to the United States from another country ◻ Y ◻ N	What Country:	
Has your child lived with or spent time with anyone who was positive for tuberculosis	◻ Yes	◻ No
Has your child lived or spent time with anyone who has a positive skin test for tuberculosis	◻ Yes	◻ No
Has your child lived with or spent time with adults who have AIDS or are infected with HIV	◻ Yes	◻ No
Has your child lived with or spent time with adults who use/used intravenous drugs or other street drugs	◻ Yes	◻ No
Has your child lived with or spent time with adults who lived in a correctional facility, nursing home or mental institution	◻ Yes	◻ No

If your child had a positive skin test for tuberculosis in the past and received treatment, inform your child's health care provider. Your child will not need another test

VACCINES FOR CHILDREN PROGRAM

PATIENT ELIGIBILITY SCREENING QUESTIONS

Parents: This information is required by the state of Massachusetts
PLEASE CHECK ONE

- ◻ This child is enrolled in Medicaid (includes MassHealth and HMO's etc., if enrolled in Medicaid)
- ◻ Does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan)
- ◻ Is Native American (American Indian) of Alaskan Indian
- ◻ Has health insurance and is not Native American (American Indian) or Alaskan Indian

Signature of Parent/Guardian: Date:

Do you want electronic access to PHI (personal health information) via Patient Gateway? ◻ YES ◻ NO