Hillsborough Pediatrics Family Demographics Sheet

Please print clearly.

Date ______/_____/_______ **Form Completed By** ____

Address ____

Street City State Zip

****Best contact phone#** (______) _____ – ________ type: ______________________

Home # (_____) _____–_______ **Work #s:** mom (______) _____–_______ dad (______) ______–_______

Cell #s: mom (______) ______ - _______ dad (______) _____ –_______ patient (______) _____ –_______

Preferred Email Address: ____

Preferred method of communication: ☐ Text ☐ E-mail ☐ Phone

How did you hear about Hillsborough Pediatrics? ____

Child's Name ____ Nickname ____________________

M ( ) F ( ) Birth Date (DOB): ______/_____/_______ Child's SS# ______ - _____ - ______

Race ________________ Ethnicity: ☐ Hispanic ☐ Non Hispanic Primary Language ______________

Child's Name ____ Nickname ____________________

M ( ) F ( ) Birth Date (DOB): ______/_____/_______ Child's SS# ______ - _____ - ______

Race ________________ Ethnicity: ☐ Hispanic ☐ Non Hispanic Primary Language ______________

Child's Name ____ Nickname ____________________

M ( ) F ( ) Birth Date (DOB): ______/_____/_______ Child's SS# ______ - _____ - ______

Race ________________ Ethnicity: ☐ Hispanic ☐ Non Hispanic Primary Language ______________

Family Information

Mother's Name ______________________ SS# ______ - ______ - _______ DOB ______/_____/______

Occupation ________________________ Employer ______________________________________

Father's Name ______________________ SS# ______ - ______ - _______ DOB ______/_____/______

Occupation ________________________ Employer ______________________________________

Emergency Contact (other than parent) ______________________________ Relation to child(ren) __________

Home # (______) ______ –_______ Work# (______) ______ –_______ Cell # (______) ______ –_______

Are there siblings not listed above? If so, please list their name(s), date(s) of birth, and where they live:

____

____

____

____

Consent for Treatment of a Minor Child
Family Form

I, being the parent or guardian of the following patient(s):

Patient Name	Date of Birth

do hereby request and authorize **Hillsborough Pediatric & Adolescent Medicine's Physicians and Staff** to perform necessary services for my child(ren) which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child(ren) in for treatment:

☐ Patient(s) by him/herself ***if*** age 16 years or older.

Name:	Relationship to Child:

Signature of Parent or Guardian ____________________ Date ____________

Printed Name of Parent or Guardian ____________________

Witness Signature ____________________ Date ____________

****Consent in effect until changed****

Family History

Patient Names: ______________________________

Directions:
If you answer yes to any of the following questions, please provide more details under "comments."

Have any biological family members had...	Father	Mother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other relatives (list)	**Comments**
Childhood hearing loss								
Nasal allergies/ hay fever								
Asthma								
Food Allergies								
Cystic Fibrosis								
Tuberculosis/ positive PPD								
Stroke (before 55 years old)								
Heart disease (before 55 years old)								
High cholesterol/takes cholesterol medication								
Anemia								
Bleeding disorder/hemophilia								
Dental decay								
Cancer (before 55 years old)								
Liver disease								
Kidney disease								
Diabetes (before 55 years old)								
Bed wetting (after 10 years old)								
Obesity								
Epilepsy/convulsions/seizures								
Alcohol abuse								
Drug abuse								
Tobacco abuse								
ADHD								
Anxiety								
Depression								
Mental health problems								
Autism								
Developmental disability or delay								
Birth defects/chromosomal abnormalities								
Immune problems, HIV, or AIDS								
Migraine headaches								
Lazy eye								
Vision problems								
Hip dysplasia or hip problems								
Any other significant problem								

Patient Past History

Patient Name: ______________________________ Date of Birth (DOB): ____/____/______

General	YES	NO	Explanation
Is your child in good health?			
Does your child have any serious illnesses?			
Has your child has any surgery? What/when?			
Has your child been hospitalized? When?			
Has your child ever been to the emergency room (ER)? When?			
Has your child ever seen a specialist? Whom?			
Does your child take any medications regularly?			
Is your child allergic to medicine or drugs? Which ones?			

Does your child have or has your child ever had:	YES	NO	WHEN?	Explanation
Chicken pox				
Frequent ear infections				
Hearing loss or problems with ears or hearing				
Nasal allergies/hay fever				
Problems with eyes or vision				
Asthma, bronchitis, bronchiolitis, or pneumonia				
Any heart problem or heart murmur				
Anemia or bleeding problem				
Blood transfusion				
Immune problems, HIV, or AIDs				
Frequent abdominal pain or constipation				
Urinary tract infections or problems				
Bed wetting (after 5 years old)				
Metabolic/genetic/chromosomal disorders				
Cancer				
Sleep problems or snoring				
Chronic or recurrent skin problems (acne/eczema)				
Frequent headaches				
Convulsions/seizures or other neurologic problems				
Obesity				
Diabetes				
Thyroid or other endocrine problems				
High blood pressure				
History of serious injuries/fractures/concussions				
Use of alcohol, tobacco, or drugs				
Smoke exposure in the home (even outside)				
ADHD				
Anxiety, depression, or mood problems (specify)				
Autism or developmental delay/difference				
Dental decay				
History of family violence				
Sexually transmitted infections				
Pregnancy				
(for girls) Problems with periods				
Any other significant problem (specify)				

Patient Past History (continued)

Patient Name: ______________________________ Date of Birth (DOB): ____/____/______

Please list all those living in the child's home:

Name	Date of Birth (DOB)	Relationship to child	Health problems	Occupation (adults)

What is the child's living situation, if not with both biological parents?

___ Adoptive Parents ___ Joint Custody ___ Other

___ Foster Family ___ Single Custody

Please explain: ____

____

Birth History

☐ I don't know birth history

Birth weight: ______lbs _____oz

Was the baby born:

☐ At term (38 – 41 weeks) ☐ Early; ____ weeks ☐ Late; ____ weeks

Where there any complications with pregnancy, delivery, or immediately after birth?

☐ No ☐ Yes, please explain: ______________________________

Was a NICU (neonatal intensive care unit) stay required?

☐ No ☐ Yes, please explain: ______________________________

During pregnancy, did mother:

☐ Use tobacco ☐ Use Drugs or Medications (what, when) ______________

☐ Drink alcohol ☐ Use Prenatal Vitamins

Was the delivery:

☐ Vaginal ☐ Cesarean: Why? ______________________________

Was baby's initial feeding:

☐ Formula ☐ Breast milk: How long breastfed ______________

Was the baby discharged from the hospital at the same time as the mother?

☐ Yes ☐ No, please explain ______________________________