NORTHSIDE
FAMILY MEDICINE
OF JOHNS CREEK
A Northside Network Provider

Your answers on this form will help your child's health care provider better understand your child's medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Patient's Name: _____ Date or Birth:___/___/_____ Date: _____

Person completing form: _____ Relationship: _____

BIRTH HISTORY

Did the mother have problems during the pregnancy (high blood pressure, high sugar, etc)? Yes ☐ No ☐

Did the mother take any medicines, drugs, or smoke cigarettes during pregnancy? Yes ☐ No ☐

If yes, please explain:

Where was the child born? ☐ Home ☐ Hospital ☐ Other:

Length of pregnancy? **Length of labor?**

Delivery type? Vaginal ☐ C-Section ☐ **Days in hospital?** **NICU?** Yes ☐ No ☐

If in NICU, list reasons why:

Birth Weight: **Birth Length:**

Problems at or soon after birth:
Jaundice Yes ☐ No ☐ Unknown ☐
Birth Defects Yes ☐ No ☐ Unknown ☐
Breathing Problems Yes ☐ No ☐ Unknown ☐
Was the newborn screen ("PKU") done? Yes ☐ No ☐ Unknown ☐
Any problems with the PKU?

Did the mother receive antibiotics during delivery? Yes ☐ No ☐ Don't know ☐

Did the mother test Group B Strep positive? Yes ☐ No ☐ Don't know ☐

Did the baby receive the Hepatitis B shot in the hospital? Yes ☐ No ☐ Don't know ☐

DEVELOPMENTAL HISTORY

Please list the age at which this child:

Started cooing _____ Sat without help _____ Started to say words _____

Pulled up on furniture _____ Started to walk _____

Do you have any concerns about the child's behavior or development? Yes ☐ No ☐

If yes, please describe:

SOCIAL HISTORY

Who lives in the child's home?

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Does anyone smoke? Inside ☐ Outside ☐ None ☐ **What kind of water does your child drink?** Well ☐ City ☐ Bottled ☐

School/Day Care Provider:

Do you have any pets? Yes ☐ No ☐ If so, what kind?

Are there guns in the home? Yes ☐ No ☐ Are they locked? Yes ☐ No ☐ Don't know ☐

PEDIATRIC NEW PATIENT FORM

PAST MEDICAL HISTORY

Are Immunizations (shots) up to date? Yes ☐ No ☐ Don't Know ☐

* Do you have a shot record? Yes ☐ No ☐ | Where have shots been given in the past?

Has the child ever had a high fever, screaming fit, or seizure after shots? Yes ☐ No ☐ Don't Know ☐

► Please list any allergies to medicine or food: ☐ No allergy to medication, food, latex or iodine

► Please list any medicine the child takes every day:

Has the child ever stayed in the hospital overnight? Yes ☐ No ☐ | If yes, please explain why:

Has the child ever had any surgeries? Yes ☐ No ☐ | If yes, please explain why:

Identify any medical problems the child has (example: asthma, allergies, or ADHD): None ☐

FAMILY HISTORY

Indicate who has had the problem: M = mother, F = father, C = child, S = sister, B = brother, MGF/MGM = maternal grandfather/grandmother, PGF/PGM = paternal grandfather/grandmother, MA/MU = maternal aunt/uncle, PA/PU= paternal aunt/uncle

- ☐ Asthma
- ☐ Allergies
- ☐ Trouble with anesthesia
- ☐ Birth defects (such as a hole in the heart, spina bifida, or Down Syndrome, etc.)
- ☐ Cancer _____
- ☐ High blood pressure
- ☐ Heart attack under age 50
- ☐ Diabetes
- ☐ Blood disorders (hemophilia/free bleeders, sickle cell disease, etc.)
- ☐ ADHD / learning problems
- ☐ Mental retardation
- ☐ Cystic fibrosis
- ☐ Tuberculosis (TB)
- ☐ Stomach disease (crohn's, ulcerative colitis, celiac disease, etc.)
- ☐ Thyroid problem
- ☐ Seizures
- ☐ Rheumatologic disease (lupus; rheumatoid arthritis, etc.)
- ☐ Mental health issues (depression, anxiety, bipolar,etc.)
- ☐ Substance abuse (alcohol or drugs)
- ☐ Babies in the family die early of SIDS or other problems
- ☐ Passing out
- ☐ Sudden unexplained death
- ☐ Other