

PATIENT MEDICAL HISTORY

Name _____ Date of Birth ____/____/____ Date _____
Person Completing Form _____ Relationship _____

SOCIAL HISTORY

Who lives in the child's home?

Name _____	Age _____	Occupation _____
Name _____	Age _____	Occupation _____
Name _____	Age _____	Occupation _____
Name _____	Age _____	Occupation _____
Name _____	Age _____	Occupation _____
Name _____	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? _____

BIRTH HISTORY

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? _____

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 _____

HEALTH HISTORY

Allergies _____

Current Medications _____

MEDICAL HISTORY

Patient Name _____ Date of Birth ____/____/____

Past/Chronic Medical problems (Example: Asthma, kidney infections, cerebral palsy): _____

SURGICAL HISTORY

Surgery _____

HOSPITALIZATIONS

Reason _____

Reason _____

Reason _____

Reason _____

Reason _____

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

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|---|---|
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Bladder or kidney infections _____ |
| <input type="checkbox"/> Ear infections _____ | <input type="checkbox"/> Kidney reflux _____ |
| <input type="checkbox"/> Hearing loss (childhood) _____ | <input type="checkbox"/> Other kidney problems _____ |
| <input type="checkbox"/> Vision problems _____ | <input type="checkbox"/> Birth defects _____ |
| <input type="checkbox"/> Strep throat _____ | <input type="checkbox"/> Anemia/blood disorder _____ |
| <input type="checkbox"/> Sinus problems _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Growth problems _____ |
| <input type="checkbox"/> Heart attack (give age) _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma/bronchitis _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Cystic fibrosis _____ | <input type="checkbox"/> Alcohol or drug abuse _____ |
| <input type="checkbox"/> Tuberculosis (TB) _____ | <input type="checkbox"/> Depression/anxiety or other psychiatric problems _____ |
| <input type="checkbox"/> Stomach or intestinal problems _____ | <input type="checkbox"/> ADHD, learning problems _____ |
| <input type="checkbox"/> Liver disease _____ | <input type="checkbox"/> Mental retardation _____ |
| | <input type="checkbox"/> Other _____ |



A Northside Network Provider

English - Spanish

Patient Name: _____ Patient DOB: _____

I understand that my child's doctor recommends that my child receive immunizations as per the Center for Disease Control (CDC) immunization schedule, and American Academy of Pediatrics guidelines.

I understand that I will be given a Vaccine Information Sheet (VIS) from the CDC for each vaccine before it is administered and I will be given the opportunity to ask questions. The VIS explains the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's doctor or nurse, who will answer my questions regarding the recommended vaccine(s), and provide the following information:

- The purpose of and the need for the recommended vaccine(s)
- The risks and benefits of the recommended vaccine(s)
- The consequences if my child does not receive the vaccine(s), which may include:
 - contracting the illness the vaccine should prevent. (The outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable disease are possible as well.)
 - transmitting the disease to others (including those too young to be vaccinated or those with immune problems)
 - requiring my child to stay out of child care or school during disease outbreaks
- My child's doctor or nurse, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control all strongly recommend that these vaccines be given according to recommendations.

I understand that by signing this form, I give consent for my child to receive recommended immunizations per the CDC Immunization Schedule, including the influenza vaccine with the exception of any immunizations refused below. While I will be given specific information for each immunization, I will not need to sign individual consents for each vaccine. This consent will be reviewed each year. I understand that I may address this issue with my child's doctor or nurse at any time and that I may re-visit decisions on immunization for my child anytime in the future.

I consent to Northside Hospital, through its agents or employees, including my child's doctor(s) and nurse(s) administering the recommended immunizations per the CDC schedule. I release Northside Hospital and its agents and employees from any and all liabilities in connection with the vaccines and the administration to my child. I acknowledge that no guarantee or assurance has been made to me concerning the results that may be obtained from the administration of the vaccines.

NORTHSIDE HOSPITAL, BY ADMINISTERING THE VACCINES TO MY CHILD PROVIDES NO WARRANTY WITH RESPECT TO THE VACCINES AND SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE CONCERNING THE VACCINES.

Georgia law requires health care providers to report all vaccinations to the Georgia Registry of Immunization Transactions and Services (GRITS). Patients are deemed to consent to reporting unless they have submitted a written request to "opt out" to the Georgia Department of Public Health.

- I represent that I have filed an "opt out" request with the Georgia Department of Public Health.
- I acknowledge that I have read this document in its entirety and all of my questions have been answered.

Witness	Date/Time	Signature of Parent or Legal Representative	Date/Time
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Interpreter Signature	Date/Time
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Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

Relationship to Patient If Not the Parent

REFUSAL OF IMMUNIZATION

I refuse to consent to administration of the following vaccine(s) which have been recommended by my child's doctor or nurse. I understand the possible consequences of refusing the vaccine(s). I understand that my child's doctor requires all parents to vaccinate their children according to the recommended schedule. The doctor or nurse will meet with me to answer questions and discuss the safety and efficacy of the vaccines. If I continue to refuse vaccination, my child will be discharged from the doctor's practice and will need to find a different pediatrician. I release Northside Hospital, the doctor(s) and their agents and employees from any and all liabilities in connection with my refusal to allow administration of the indicated vaccine(s) to my child.

- | | | |
|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Refuse all vaccines | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Witness	Date/Time	Signature of Parent or Legal Representative	Date/Time
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Interpreter Signature	Date/Time
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Interpreter comments (optional): _____

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