Prime Pediatrics & Adolescent

1063 W Hill Rd Suite A
Flint, MI 48507
P: (810) 733-0010
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Date: _____

Patient Information:

Name: Last _____First _____MI _____ Gender M/F

Date of Birth _____

Race: American Indian or Alaskan Native – Caucasian - African-American - Pacific Islander – Decline
Ethnicity: Hispanic Non Hispanic Decline
Preferred Language: English Spanish Other _____

Address _____Phone # _____Email _____

Mother's Name _____ Date of Birth _____Occupation _____

Phone Number: _____

Father's Name _____ Date of Birth _____Occupation _____

Phone Number: _____

Parent's Marital Status: __ Married __ Divorced __ Single __ Other _____

Daycare? _____ Who has custody of the child? _____

Does anyone smoke in the home? __ No __ Yes Pets? __ No __ Yes

Person to contact in case of an emergency if unable to reach the parent/legal guardian listed above.

Name: _____ Phone: ( ) _____

Relationship to patient: _____ Address: _____

Preferred Pharmacy/address _____

Birth History:

Birth Weight _____ Which type of delivery: __ Vaginal __ C-Section
Birth Height _____
Was the child born early? __ No __ Yes
If yes, how many weeks gestation? _____
Did the mother have any illness or problems during the pregnancy? __ No __ Yes
If yes, explain _____
Did the child have any problems right after birth? __ No __ Yes
If yes, explain _____
What type of feeding? __ Breast __ Formula
Did the child require treatment for jaundice? __ No __ Yes
Did the child pass the newborn hearing test? __ No __ Yes

Siblings:

Name _____ Age ____ Name _____ Age _____
Name _____ Age ____ Name _____ Age _____

Medical History:

Does the child have allergies to medicine(s)? __ No __ Yes

If yes, give medicine(s) name and explain reaction(s) _____

Does the child take any medication(s) on a daily basis? _____

Has the Child Ever Had?	**No**	**Yes**	**Has the Child Ever Had?**		**No**	**Yes**
Allergies			Hearing Problems			
Anemia			Heart Murmur			
Asthma			Heart Problems			
Bladder or Kidney Infection			Kidney Disease			
Chicken Pox			Middle Ear Infections			
Developmental Delay			Pneumonia			
Diabetes			Seizure			
Vision Problems			ADHD/ADD			
Eczema			Food Allergies			
Gastrointestinal Reflux			Mental Illness			
Seasonal Allergies			Recurrent Ear Infections			
Other			Other			

Surgical History:

Has the Child Ever Had?	**No**	**Yes**	**Has the Child Ever Had?**	**No**	**Yes**
Adenoidectomy			Circumcision		
Ear Tubes			Hernia Repair		
Tonsillectomy					
Other			Other		

Family History:

Mom:_____

Dad: _____

Siblings:_____

Time: _____ Date _____Person Completing Form Signature _____

If not patient, relationship to patient _____