

# WELCOME TO Lakeside Primary Care

In order to us to get to know you and your health care needs, please fill out the following form to the best of your ability. Our goal is to provide you with exceptional health care, and it starts with getting to know you.

Please let us know how you heard about our practice. Check all the ways that we have caught your attention.

Billboards \_\_\_\_\_ Website \_\_\_\_\_ Other \_\_\_\_\_  
 Magazine ads \_\_\_\_\_ Personal referral \_\_\_\_\_  
 Mailing \_\_\_\_\_ Google search \_\_\_\_\_  
 Previous patient of the physician \_\_\_\_\_ Commercial \_\_\_\_\_

## MEDICAL HEALTH HISTORY UNDER 10 YEARS OF AGE

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ AGE: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Legal Guardian's Name: \_\_\_\_\_

*Please circle the best response:*

Race Information: White Black/African American Asian Alaskan Native American

Pacific Islander Hispanic/Latino Non-hispanic Latino More than one race I prefer not to disclose

## CHILD'S PAST MEDICAL HISTORY

Birth history: Weight at birth \_\_\_\_\_

Was the pregnancy full term (37-40 weeks)? Yes \_\_\_ No\_\_\_ How many weeks if known? \_\_\_\_\_

Was child's delivery by vaginal birth or c-section? \_\_\_\_\_

Any problems during pregnancy or delivery? No\_\_\_ Yes, explain \_\_\_\_\_

Birth occurred: Full term (37-40 weeks) \_\_\_ Pre-term (Less than 37 weeks)\_\_\_ Number of weeks \_\_\_\_\_

Did baby require special care in the Newborn Nursery? No\_\_\_ Yes, explain \_\_\_\_\_

Has your child's development been normal? Yes No, explain \_\_\_\_\_

**PLEASE PLACE AN "X" IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS**

ACID REFLUX	ENLARGED TONSILS	PALPITATIONS
ADHD	ENLARGED ADENOIDS	POOR HEARING
ALLERGIES	FATIGUE	POOR VISION
ANEMIA	HEADACHE	POOR WEIGHT GAIN
ANXIETY	HEART MURMUR	PREMATURITY
ASTHMA	HEMORRHOIDS	RECURRENT EAR INFECTIONS
BACK PAIN	HIGH CHOLESTEROL	SEIZURES
BRONCHIOLITIS	HIGH BLOOD PRESSURE	SEXUALLY TRANSMITTED DISEASE
CHICKEN POX	HYPOTHYROIDISM	SLEEP APNEA
CONSTIPATION	IRRITABLE BOWEL DISEASE	STRABISMUS
DEPRESSION	JUVENILE RHEUMATOID ARTHRITIS	URINARY TRACT INFECTIONS
DIABETES - JUVENILE	LOSS OF WEIGHT	WHEEZING
DIABETES TYPE 2	MIGRAINES	OTHER:
DRUG ABUSE	OBESITY	OTHER:

**CHILD'S ALLERGIES:** \_\_\_\_\_

**CHILD'S MEDICATIONS (INCLUDE NAME / /DOSE / HOW TAKEN)**

**CHILD'S HOSPITALIZATIONS (Reason)**

**DATE**

**CHILD'S SURGERIES (Date)**

Addenoidectomy \_\_\_\_\_

Pyloric Stenosis Repair \_\_\_\_\_

Appendectomy \_\_\_\_\_

Tonsillectomy \_\_\_\_\_

Endoscopy \_\_\_\_\_

Tonsils and adenoids \_\_\_\_\_

Inguinal hernia repair \_\_\_\_\_

Tubes in ears \_\_\_\_\_

Umbilical hernia repair \_\_\_\_\_

Other \_\_\_\_\_

**CHILD'S SOCIAL HISTORY**

Lives with : Parents \_\_\_ Mother \_\_\_ Father \_\_\_ Stepfather \_\_\_ Stepmother \_\_\_ Sisters \_\_\_

Brother \_\_\_ Half Siblings \_\_\_ Grandparent \_\_\_ Other \_\_\_\_\_

Siblings names and ages: \_\_\_\_\_

Shared Custody: With dad one day per wk/weekends \_\_\_ With mom one day per wk/weekends \_\_\_

Other \_\_\_\_\_

Childcare: Parents \_\_\_ Family \_\_\_ Daycare \_\_\_

Smoking status if 11 years or older: Tobacco \_\_\_ Snuff \_\_\_ Chew \_\_\_ None \_\_\_

Smokers in the home: No \_\_\_ Yes \_\_\_ Outside Only \_\_\_

Smoke detectors in home: No \_\_\_ Yes \_\_\_

Pool: No \_\_\_ Yes \_\_\_ Pool Fenced? No \_\_\_ Yes \_\_\_

Exercise: Sports \_\_\_\_\_ Other adequate \_\_\_\_\_ Inactive \_\_\_\_\_

Weapons in the home: No \_\_\_ Yes \_\_\_ Guns locked? No \_\_\_ Yes \_\_\_

Pets: None \_\_\_ Dog \_\_\_ Cat \_\_\_ Fish \_\_\_ Other \_\_\_\_\_

Water: City \_\_\_ Well \_\_\_ Flouride \_\_\_

TV/Computer time daily: <2hrs \_\_\_ >2hrs \_\_\_

Grade: \_\_\_\_\_ Grades: Good \_\_\_ Fair \_\_\_ Poor \_\_\_

School Problems: None \_\_\_ Behvaioral \_\_\_ Bullying \_\_\_ Attendance \_\_\_

Plans After High School: College \_\_\_ Military \_\_\_ Trade \_\_\_ School \_\_\_ Undecided \_\_\_

**CHILD'S FAMILY HISTORY** (Any family member /relative including mother, father, mother's parents, father's parents, brother or sister)

**Illness**

**Family Member/Relative who has illness**

- Allergies/Sinusitis \_\_\_\_\_
- Asthma \_\_\_\_\_
- Lung disease \_\_\_\_\_
- Birth Defects \_\_\_\_\_
- Blood Disorders \_\_\_\_\_
- Bone/Joint Disorders \_\_\_\_\_
- Cancer \_\_\_\_\_
- Leukemia \_\_\_\_\_
- Eye Disorders \_\_\_\_\_
- Ear Disorders \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Thyroid Disease \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Mental Retardation/Delay \_\_\_\_\_
- Muscle Disease/Multiple Sclerosis \_\_\_\_\_
- Muscular Dystrophy \_\_\_\_\_
- Psychiatric Disorders \_\_\_\_\_
- Seizures \_\_\_\_\_
- Cerebral Palsy \_\_\_\_\_
- Stomach Disease or Ulcers \_\_\_\_\_
- Colitis \_\_\_\_\_
- Other \_\_\_\_\_