Saline Pediatric Associates

Saline Health System

Patient Name: _____ Date of Birth: ___/___/___

Date: ___/___/___ Reason for Visit: _____

Who is accompaning the patient? _____

Allergies

List All allergies (including medication, food and environment)

☐ No known Allergies

Allergen	Reaction

Vaccinations

Select any vaccines that the patient has had

☐ No vaccines as of today

Does the child have any conditions that prevent them from being vaccinated? Yes / No

▸ If yes, please explain? _____

Vaccine	Approximate Dates	Vaccine	Approximate Dates
☐ DTaP		☐ Flu	
☐ MMR		☐ COVID-19	
☐ Hepatitis B		☐ Meningococcal	
☐ Hepatitis C		☐ Pnuemococcal	
☐ Hib		☐ Rotavirus	
☐ HPV		☐ Meningitis	
☐ Varicella		☐ _____	
☐ Polio (IVP)		☐ _____	

Saline Health System
SALINE CLINICS

Medications

☐ No medications

Please List all medications that you currently take (including Over-the counter, herbs and vitamins)

Medication Name	Dose	How often?	Reason For Taking

Saline Health System
SALINE CLINICS

Family History

☐ Family History Unknown

Do any blood relatives (sibling, parent, grandparent, aunt/uncle, cousins) have any of the following? Indicate Maternal or Paternal

	Relative(s)	Current Age / Age at Death
☐ Autism		
☐ Diabetes		
☐ Kidney Issues		
☐ Stroke		
☐ Heart Attack		
☐ High Blood Pressure		
☐ Auto Immune Disease		
☐ Lung Conditions		
☐ Blood Disease		
☐ Cancer and type		
☐ Other		

Social History

Diet ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Cardiac ☐ Diabetic

☐ Other (Please Explain) _____

Caffine Intake ☐ None ☐ Occasional (1-3 / Month) ☐ Moderate (1-3 / week) ☐ Heavy (1-3 / Day)

Sporting Activites _____

Parents are: ☐ Married ☐ Legal Domestic Partnership ☐ Divorced/Separated ☐ Unmarried

Who lives in the home with your child ☐ Mom ☐ Dad ☐ Step: Mother / Father ☐ Spouse / Sig. Other
☐ Grand: Mother / Father ☐ Siblings (#_____)

☐ Other _____

Childcare: ☐ Parent ☐ Relatives ☐ Daycare ☐ Babysitter/Nanny

Please check "Yes" or "No" to the following:

	Yes	No
Smoking of Vaping in the home		
Animlas in or around the home		
Smoke/CO detectors in home		
Seatbelt/ Carseat used routinely		
Sunscreen used routinely		

	Yes	No
Insect repellent used routinely		
Guns present in the home		
Wears a bike helmet routinely		
Issues with bullying/bully		
Home water florinated		

Saline Health System
SALINE CLINICS

Social History

Year in school _____ School Name _____

Changes in family/social situation Yes / No Explain _____

_____

Does family ever have difficulty making ends meet at the end of the month? Yes / No

Family has moved frequently/lived with others due to finances within the last year? Yes / No

Concerns about meeting basic needs (food, housing, heat, etc) Yes / No

Sexual History

Sexually Active? Yes / No How long? _____ How many partners? _____

Gender Identity? _____ Sex assigned at birth? _____

Pronouns He/Him She/Her They/Them

First Name Used _____ Sexual Orientation _____

Surgical History

List all surgical procedures the child has had

☐ No Surgeries

Surgery	Date	Surgery	Date

Saline Health System
SALINE CLINICS

Medical History

☐ No previous medical history

Select all that apply to the patient directly. For any condition not listed use the "Other" line.

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Tourettes Syndrome
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Other _____

Heart/Blood
- ☐ Heart Murmur
- ☐ Patent ductus arteriosus
- ☐ Arrhythmia
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Other _____

Kidney/Bladder
- ☐ Kidney Stones
- ☐ Frequent UTIs
- ☐ Urinary Frequency
- ☐ Difficulty Urinating
- ☐ Incontinence
- ☐ Other _____

GI Issues
- ☐ Acid Reflux (GERD)
- ☐ Constipation
- ☐ Frequent Stool
- ☐ Stomach/Esophageal Ulcers
- ☐ Trouble Swallowing
- ☐ Other _____

Skin
- ☐ Dermatologic Disorders
- ☐ Eczema
- ☐ Non-healing/Open Wounds
- ☐ Other _____

Other
- ☐ Seizures/Epilepsy
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Multiple Sclerosis
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Cancer
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Birth History

Where was your child born? _____ Birth Weight: _____ Length: _____

Weeks Pregnant at birth? _____ Was the pregnancy a multiple (i.e. Twins)? Yes / No

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Grandchild ☐ Other _____

Delivered by: ☐ Vaginal ☐ C-Section Reason for C-Section: _____

Did your child go to the NICU? Yes / No Did your child require oxygen? Yes / No

Other problems in the new born period? _____