Saline Health System
SALINE CLINICS

Saline Pediatric Associates

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Pediatric Primary Care
Dr. Jamie Irwin
Dr. Ajitha Yeluru

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 A		☐ Meningococcal	
☐ Hepatitis B		☐ Pnuemococcal	
☐ Hib		☐ Rotavirus	
☐ HPV		☐ Meningitis	
☐ Varicella		☐ _____	
☐ Polio (IVP)		☐ _____	

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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

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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 _____

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		

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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? _____

Nutrition History

Select all that apply: ☐ Breast Fed ☐ Bottle Fed ☐ Formula Fed ☐ Formula Supplement

Which Formula Do You Use? _____ Eating Solid Foods? Yes / No

If breast feeding, are you having any difficulties? _____

_____

How many ounces a feeding? _____ How many feedings a day? _____

Social History

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

Caregivers Occupations: _____

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

Childcare: ☐ Parent ☐ Relatives ☐ Daycare ☐ Babysitter/Nanny Days/Week? _____

Does anyone smoke or vape around your child? Yes / No

What type of carseat is your child using? ☐ Carrier Seat ☐ Convertible Seat ☐ Booster Seat

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Surgical History

List all surgical procedures the child has had

☐ No Surgeries

Surgery	Date	Surgery	Date