C & C Medical Associates Pediatric Clinic, Federal Way, WA

Patient History Chart

Allergies:_____

I.D.	PATIENT'S NAME		BIRTHDATE	SEX	DATE
	ADDRESS		RACE	AGE	PHONE
	CITY	STATE ZIP	PREVIOUS PHYSICIAN	ADDRESS	
EMERGENCY CONTACT			REFERRED BY		
FATHER'S NAME		SOCIAL SECURITY #	MOTHER'S NAME		SOCIAL SECURITY #
WHERE EMPLOYED		OCCUPATION	WHERE EMPLOYED		OCCUPATION
EMPLOYER'S ADDRESS		WORK PHONE NUMBER	EMPLOYER'S ADDRESS		WORK PHONE NUMBER
INSURANCE COMPANY		I.D. #	INSURANCE COMPANY		I.D. #

PATIENT'S FAMILY HISTORY — DRIVER'S LICENSE NUMBERS: FATHER _____ MOTHER _____

	NAME	BIRTHDATE	ANY CURRENT HEALTH PROBLEMS	CHECK ANY PRESENT IN FAMILY	RELATION TO PATIENT
MOTHER				( ) TUBERCULOSIS	
FATHER				( ) DIABETES	
BRO / SIS				( ) HEART DISEASE	
BRO / SIS				( ) LUNG DISEASE	
BRO / SIS				( ) KIDNEY DISEASE	
BRO / SIS				( ) LIVER DISEASE	
BRO / SIS				( ) CANCER	
				( ) HIGH BLOOD PRESSURE	
				( ) SEIZURES	
				( ) HIGH CHOLESTEROL	
				( ) BLOOD DISORDER	
				( ) MENTAL	
				( ) ALLERGIES	
				( ) OTHER:	

HOUSING ☐ HOUSE ☐ APT ☐ TRAILER PETS _____
WATER ☐ CITY ☐ BOTTLE ☐ WELL SMOKERS _____

BIRTH HISTORY | WHEN THIS CHILD WAS BORN, MOTHER WAS_____YRS OLD | THIS WAS PREGNANCY NO.____ | THIS WAS LIVE BORN BABY NO._____ | PREVIOUS MISCARRIAGES_____ | NUMBER CHILDREN NOW LIVING _____

TYPE OF DELIVERY: ☐ VAGINAL ☐ C-SECTION for_____ ☐ BREECH
DURATION OF PREGNANCY WEEKS ☐ EARLY ☐ LATE
ILLNESS OR COMPLICATIONS — GBS + / -
DELIVERED BY DOCTOR — Treated x _____
HOSPITAL / CITY
BIRTH WEIGHT LENGTH HEAD CIRC.
APGAR SCORE CIRCUMCISION ☐ YES ☐ NO
NURSERY STAY
JAUNDICE MEDICATION HEARING SCREEN ☐ PASS ☐ REFER
HOSPITAL DISCHARGE AGE WEIGHT BLOOD TYPE

MEDICAL HISTORY

DEVELOPMENTAL HISTORY

NUTRITION HISTORY

GENERAL HEALTH

SERIOUS ILLNESS OR INJURIES

CHILDHOOD DISEASES
☐ CHICKEN POX - DATE/AGE ☐ FREQUENT THROAT INFECTIONS
☐ FREQUENT EAR INFECTIONS ☐ ASTHMA / BRONCHITIS

HOSPITALIZATION / OPERATIONS

TB SKIN TEST	DATE	RESULT	TYPE	AGE	DATE	TYPE	RESULT
AGE							

SIGNATURE OF PARENT / GUARDIAN

SITE LEGEND
RA-RIGHT ARM
LA-LEFT ARM
RT-RIGHT THIGH
LT-LEFT THIGH
O-ORAL

VACCINE	OTHER	VIS	DATE GIVEN M / D / Y	SITE	VACCINE MANUFACTURER & LOT	EXP. DATE	ADMIN INITIALS	PARENT/ GUARDIAN INITIALS
DT P 1								
DT P 2								
DT P 3								
DT P 4								
DT P 5								
Td/Tdap								
HIB								
HIB								
HIB								
HIB								
IPV								
IPV								
IPV								
IPV								
Hep B 1								
Hep B 2								
Hep B 3								
Hep B 4								
PCV 7								
PCV 7								
PCV 7								
PCV 7								
PPV-23								
Rotateq								
Rotateq								
Rotateq								
MMR								
MMR								
Varivax								
Varivax								
Hep A								
Hep A								
Menactra								
Menomune								
Flu								
Flu								