

**Confidential**

**Please complete this form to help us give you the best possible care.  
Let us know if you would like help completing this form.**

Child's Name (first, middle, last): \_\_\_\_\_

Has your child ever been seen under a different name?  Yes  No If yes, what was that name? \_\_\_\_\_

Sex:  M  F Date of birth: (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_ Best Contact Number: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Best Contact Number: ( ) \_\_\_\_\_

**Ethnicity**

**Please answer both questions**

1. HISPANIC/LATINO ETHNICITY:

- Hispanic/Latino
- Not Hispanic/Latino

2. RACE

- Asian
- Native Hawaiian
- Other Pacific Islander
- Black/African American
- American Indian/Alaska Native
- White
- Unreported or Refused to Report

**Primary Language**

\_\_\_\_\_

**Parent or Guardian Information**

1. Do you consider yourself homeless?  Yes  No
2. Do you live in Public Housing?  Yes  No

**Farm Worker Status**

1. Has the primary source of work for you or a member of your family **ever** been farm work?  
 Yes  No **If, YES -proceed to question 2**
2. In the past 2 years, did you or a member of your family move here or someplace else to do farm work?  Yes  No **If, NO-proceed to question 3**
3. Have you or a member of your family **ever** moved somewhere to do farm work?  Yes  No **If, YES proceed to question 4. If, NO proceed to question 5**
4. Is the reason you or your family member are not doing farm work because you/they were disabled or too old to do the work?  Yes  No
3. Do you or your family member now do farm work on a seasonal basis?  Yes  No

I certify the information I have provided is correct and hereby consent to authorize all examinations including physical exams, x-ray and laboratory procedures, which may be necessary in the judgment of the physician for diagnostic purposes.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Centricity ID # \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of birth: (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

<b>Check conditions below that YOUR Child has now or has had in the past</b>		<b>Allergies:</b>	
<input type="checkbox"/> Alcoholism/drug addiction <input type="checkbox"/> High blood pressure <input type="checkbox"/> Anemia <input type="checkbox"/> Kidney disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Lung disease <input type="checkbox"/> Asthma <input type="checkbox"/> Mental health problems <input type="checkbox"/> Bleeding problem <input type="checkbox"/> Migraines <input type="checkbox"/> Blood clot in leg or lung <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Cancer –type: _____ <input type="checkbox"/> Sexually transmitted infection <input type="checkbox"/> Depression <input type="checkbox"/> Stomach problems <input type="checkbox"/> Diabetes – type: _____ <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy /Seizures <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Genital discharge / pain <input type="checkbox"/> Thyroid _____ <input type="checkbox"/> Heart Disease / Attack <input type="checkbox"/> Ulcer <input type="checkbox"/> Hepatitis – type: _____ <input type="checkbox"/> Urinary problems / pain		<b>Current Medications:</b> <i>Include prescription, vitamins and over the counter / herbal preparations.</i>	
		<b>IMMUNIZATIONS</b>	
		<b>Are your child’s immunizations up to date?</b>	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
<b>Has your child been hospitalized, or had surgery or any serious injuries or illnesses?</b>		<b>MOTHERS PREGNANCY HISTORY</b>	
<b>If so, please list below:</b>	<b>Year</b>	<b>Pregnancy:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <b>Labor:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <b>Delivery:</b> <input type="checkbox"/> Normal <input type="checkbox"/> C-Section <b>Feeding:</b> <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <b>Comments:</b> _____	
<b>FAMILY HISTORY</b>		<b>SOCIAL HISTORY</b>	
<b>Check if any family members have had any of the following.</b> <i>Write relationship to you in the space.</i>		<ol style="list-style-type: none"> <li>1. Do you feel the child is physically and emotionally safe in the family and your home? <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>2. Do you have financial concerns? <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>3. Does the child have any vision problems? <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>4. Does the child have any hearing problems? <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>5. Does the child have any learning problems? <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>6. Does the child have any emotional problems? <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>7. Does the child get regular exercise? <input type="checkbox"/> Yes   <input type="checkbox"/> No   If yes, activity: _____ How often? _____</li> <li>8. Does the child use Alcohol? <input type="checkbox"/> Yes   <input type="checkbox"/> No If yes, type: _____ frequency: _____</li> <li>9. Does the child use Illegal Drugs? <input type="checkbox"/> Yes   <input type="checkbox"/> No If yes, type: _____ frequency: _____</li> <li>10. Does the child use Tobacco? <input type="checkbox"/> Yes   <input type="checkbox"/> No If yes, type: _____ # times per day: _____ since: _____</li> </ol>	
<input type="checkbox"/> Alcoholism, drug addiction <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer – type: _____ <input type="checkbox"/> Depression /Mental health problems <input type="checkbox"/> Diabetes-type: _____ <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis-type: _____ <input type="checkbox"/> High blood pressure <input type="checkbox"/> Lung disease (emphysema/TB) <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid <input type="checkbox"/> Other _____			



**PATIENT REGISTRATION HEALTH HISTORY BIRTH TO 17**

AA54.PT.FRM

<b>PHYSICAL DEVELOPMENT</b>	
<b>At What age did your child:</b> Sit Up: _____ Talk: _____ Walk: _____ Self Feed: _____ First Menstrual Cycle (if applicable): _____	

**Completed by:** \_\_\_\_\_

**Relationship to child:** \_\_\_\_\_

**Provider Review** \_\_\_\_\_

**Date:** \_\_\_\_\_