HopeCentral
Pediatrics and Behavioral Health
for Seattle's Rainier Valley

HopeCentral Pediatric Patient History

Patient Name: Date:
Date of Birth: Age: Patient phone number:
Patient's Address (include zip code):

Reason for Visit:

A. **PARENT/GUARDIAN INFORMATION (Please check if address is the same as patients: ☐)**

Parent 1		Parent 2	
Parent 1 Name:		Parent 2 Name:	
Date of Birth:		Date of Birth:	
Address:		Address:	
Email:		Email:	
OK to Leave Message*?		OK to Leave Message*?	Email:
Voicemail: ☐Yes ☐ No	Home Number:	Voicemail: ☐Yes ☐ No	Home Number:
Voicemail: ☐Yes ☐ No	Work Number:	Voicemail: ☐Yes ☐ No	Work Number:
Voicemail: ☐Yes ☐ No Text: ☐Yes ☐ No	Mobile Number:	Voicemail: ☐Yes ☐ No Text: ☐Yes ☐ No	Mobile Number:

**Message may contain personal health information*

B. DEMOGRAPHICS (Federal programs require us to ask for the following information. Your answers will not affect your care or treatment in any way and you may choose to decline to answer.):

Patient's ethnicity:
☐Decline to answer ☐Hispanic or Latino ☐Not Hispanic or Latino

Patient's race:
☐Decline to Answer
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White

C. PAST MEDICAL HISTORY

1. **Birth History**: Birth Weight: Length: ☐ Full Term /☐ Premature (check one)

   a) **Pregnancy problems** or infections:

   b) Labor/Delivery: ☐ Vaginal / ☐ C-section (check one) Describe **any problems**:

   c) Problems in the Nursery/ 1st month of life:

2. List any **medical problems** that your child has:

3. List any **hospitalizations** that your child has had. Include his/her age, where hospitalized, and the reason for the hospitalization.

4. List any **surgeries/procedures** with the approximate dates performed that your child has had. Include those done as an outpatient:

5. List all **medications** (include over the counter and herbal therapies).

6. **Drug Allergies**:

7. Are immunizations up to date?
☐ Yes ☐ No

D. FAMILY HISTORY

1. Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

☐ Adhd
☐ Allergies/Hay Fever
☐ Asthma
☐ Autism spectrum disorder (ASD)
☐ Infant/Child Death
☐ Bleeding Problems
☐ Cancer
☐ Heart Disease
☐ Hypertension
☐ Headaches
☐ Prolonged or recurrent infections
☐ Diabetes
☐ Lipids/High Cholesterol
☐ Kidney Disease
☐ Gastrointestinal Disorder
☐ Sickle cell disease
☐ Reflux/Stomach Ulcer
☐ Crohn's Disease/Ulcerative Colitis
☐ Immunodeficiencies
☐ Liver & Gallbladder Disease
☐ Cystic Fibrosis
☐ Unexplained death
☐ Unexplained fevers
☐ Blood Disorders
☐ Lung Problems
☐ Amyloidosis
☐ Fam. Mediterranean Fever
☐ HIV

2. Is there any other disease/illness that runs in the family?

E. SOCIAL HISTORY:

1. Who lives in the same household with the patient?

Name	Age	Relationship to Patient	Any Health Problems?

3. **School History**:
   A) Grade in school:
   B) Performance/Grades:
   C) Recent change in behavior/performance?

2. Are the **parent**(s): ☐ Single ☐ Married ☐ Remarried
☐ Separated ☐ Divorced

4. Any unusual **stresses** at home or school?
☐ No ☐ Yes (explain) ____
____

5. Who **smokes** in the family?

6. **Exposures:**
☐ Travel? ☐ Camping ☐ Mosquitoes or Ticks
☐ Pets? ☐ Snakes ☐ Lizards ☐ Turtles ☐ Birds
☐ Unpasteurized dairy products ☐ Raw fish or meat ☐ Blood transfusions

7. **Sick Contacts**: Water Source (check): ☐ City ☐ Well Swimming? ☐ Pool ☐ Lakes ☐ Ponds

F. SPIRITUAL HISTORY:

At HopeCentral we view spirituality as integral to healthcare. We have adapted the questions below from the FICA Spiritual Assessment created by Dr. Catherine Puchalski and the George Washington Institute for Spirituality & Health. Please talk to your provider if you have any questions.

1. Faith and Belief

Do you consider your family spiritual or religious?

Does your family have beliefs that help it cope with stress?

2. Community

Is your family part of a spiritual or religious community?

Is there a group of people your family really loves or who are important to your family?

3. Addressing Spirituality

How would you like me, your healthcare provider, to address these issues in your healthcare?

G. REVIEW OF SYSTEMS: Please check any of the following that are problems for your child:

General
- ☐ Recurrent fevers/temperatures
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Skin
- ☐ Skin rashes/boils
- ☐ Acne
- ☐ Easy bruising

Ears, Nose, Throat
- ☐ Ear pain
- ☐ Ear infections
- ☐ Discharge from ears
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Mouth ulcers
- ☐ Trouble swallowing
- ☐ Hoarseness
- ☐ Red or yellow eyes
- ☐ Sore throat
- ☐ Dental problems

Gastrointestinal (Stomach / Intestines)
- ☐ Constipation (hard or infrequent stools)
- ☐ Lack of appetite
- ☐ Diarrhea
- ☐ Nausea/Vomiting/spitting up
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Difficulty swallowing
- ☐ Stomach pain
- ☐ Liver problems/jaundice/hepatitis
- ☐ Other problems

Heart/ Blood vessels
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations (fast heart beat)
- ☐ Irregular heart beat
- ☐ Blood pressure problems

Genital/Urinary System
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Increased frequency or amount of urine
- ☐ Swelling/retaining water
- ☐ Other urinary tract or kidney problems
- ☐ Menstrual problems
- ☐ Age at first menstrual period______
- ☐ Date last menstrual period ended_____

☐ ***Endocrine (Glands)***
- ☐ Thyroid problems
- ☐ Poor growth
- ☐ Other hormone/gland problems

Neurologic (Brain / Nerves)
- ☐ Developmental delay
- ☐ Headaches
- ☐ Seizures
- ☐ Dizziness
- ☐ Fainting
- ☐ Changes in behavior
- ☐ Decreased sensation
- ☐ Decreased muscle strength
- ☐ Other neurologic problems

Breathing/ Lungs/ Chest
- ☐ Coughing
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Apnea (stops breathing)
- ☐ Pneumonia

Breasts
- ☐ Discharge from nipples
- ☐ Breast lumps/masses
- ☐ Other skin problems

Musculoskeletal
- ☐ Joint redness or swelling
- ☐ Weakness
- ☐ Muscle pain

☐ ***Allergy/Immune System***
- ☐ Allergies
- ☐ Immune problems
- ☐ Frequent infections
- Unusual infections

Eyes
- ☐ Wear glasses | contact lenses
- ☐ Blurry vision
- ☐ Double vision
- ☐ Eye pain

Hematologic (Blood problems)
- ☐ Bleeding disorders/easy bleeding
- ☐ Anemia
- ☐ Received blood transfusions
- ☐ Easy bruising
- ☐ Swollen lymph nodes
- ☐ Lumps/growths

Other relevant information or concerns:

Office Use Only

____ ________________________

Provider Signature Date