Pediatric Well Visit Form

Date: ____________________

Patient Infomation

Name: ______________________________________ Date of Birth: __________

Last *First* *M.I.*

Preferred **Local** Pharmacy:	
Preferred **Mail Order** Pharmacy:	

Social History

Who do you currently Live with:	Mother Father Both Other: ____________________
Mother's Name:	Age: Health: Occupation: ____________________ Education (Last grade completed):
Father's Name:	Age: Health: Occupation: ____________________ Education (Last grade completed):
Brother's Name:	Age: Health:
Brother's Name:	Age: Health:
Brother's Name:	Age: Health:
Sister's Name:	Age: Health
Sister's Name:	Age: Health:
Sister's Name:	Age: Health:
Parents' Marital Status	Married Divorced Never Married Separated If Divorced, who has legal custody?
Residence City Name:	House Apartment Flat Mobile Home
Who Lives in Home?	
Child's School:	Grade: Grades: Above Average Average Poor
Preschooler: In Day Care? YES NO	If YES number of days per week:
Allergies:	
Has child seen another physician in the last year? If yes, who and where?	

Current Medications

Please include all prescriptions, over the counter, vitamins and supplements child is currently taking

Name/ Dose of Medication	Reason for taking Medication

Risk Factors

Smokers in Home?	Parents: YES NO Sitter: YES NO Grandparents: YES NO
Guns in Home? YES NO	If YES, are they locked away and unloaded
Smoke Detector in Home? YES NO	Does the child wear seatbelt? YES NO
Does the child use a child seat?	YES NO

Family Medical History

Medical Problems (Relatives of the patient)
0= None M= Mother F= Father S/B= Sister/Brother
GP= Grandparent A/U= Aunt Uncle GGP= Great Grandparent

	0	M	F	S/B	GP	A/U	GGP
Tuberculosis (T.B.)							
Allergy/Asthma							
Heart Attack before age 40							
Diabetes							
Hypoglycemic (Low Blood Sugar)							
Convulsions							
Heart Disorder							
Cancer							
Hypertension (High Blood Pressure							
Arthritis							
Kidney/Bladder Disorder							
Stroke							
Bleeding Disorder							
Muscle Disorder							
Developmental Delay or Retardation							
Other:							

History of Birth Defects: ____

History of S.I.D.S.: ____

Social Determinants (As a household)

In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?	YES NO
In the last 12 months has your utility company shut off your service for not paying your bills?	YES NO
Are you worried in the next 2 months you may not have stable housing?	YES NO
Do problems getting child care make it difficult for you to work or study? (leave blank if you don't have children)	YES NO
In the last 12 months have you needed to see a doctor but could not because of cost?	YES NO
In the last 12 months have you ever had to go without healthcare because you didn't have a way to get there?	YES NO
Do you ever need help reading hospital materials?	YES NO
Are you afraid you might be hurt in your apartment building or house?	YES NO
If you checked YES to any above, would you like to receive assistance with any of these needs?	YES NO
Are any of these needs urgent? For example: I don't have food for tonight, I don't have a place to sleep tonight.	YES NO