HEALTH CARE FOR CHILDREN, PC

9051 NE 81st Terr • Suite 100 • Kansas City, Missouri 64158
Telephone (816) 792-1170

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Patient Information (May be requested annually)

Patient's Name _____ Gender _____ Pref. or Nickname _____

Date of Birth _____ Home Phone _____

Address _____ Cell Phone _____ Child/Mother/Father

_____ Cell Phone _____ *Child/Mother/Father*

Other Children Seen Here

Names	DOB	Sex M	Sex F	Names	DOB	Sex M	Sex F
_____		☐	☐	_____		☐	☐
_____		☐	☐	_____		☐	☐
_____		☐	☐	_____		☐	☐
_____		☐	☐	_____		☐	☐

Parent(s) or Guardian(s) Information

Parent #1 / Financially responsible _____ SS # _____

Relationship to patient _____ DOB _____

Employer _____ Occupation _____

E-mail address _____ Home Phone _____

Address if different from child _____ Cell Phone _____

_____ Work Phone _____

Parent #2 _____ SS # _____

Relationship to patient _____ DOB _____

Employer _____ Occupation _____

E-mail address _____ Home Phone _____

Address if different from child _____ Cell Phone _____

_____ Work Phone _____

Insurance Subscriber _____ DOB _____

Nearest relative NOT living with you:

Name _____ Phone _____

Address _____

City _____ State _____ ZIP _____

Your signature allows us to use electronic prescription verification.

I agree to pay the charges for the medical care of the above named child.
I authorize Health Care for Children PC to furnish my insurance company with medical records.
I also authorize my insurance company to pay Health Care for Children PC directly.
I understand my insurance policy is a contract between my insurance company and myself and that Health Care for Children PC files insurance as a courtesy.
I also understand that if my insurance company does not pay within 90 days, I will be billed.

Signature of Parent or Guardian _____ Date _____

MEDICAL HISTORY **Patient Name_____ DOB_____**

Past Medical History:
Birth weight: _____Due date: _____Pediatrician at birth:_____

Place of birth_____ Time of Birth_____

Problems during pregnancy, labor, delivery_____

Problems with baby after delivery_____

Type of delivery (Vaginal, C-Sections, Forceps etc)_____
Nutrition:
Breastfeeding_____Bottlefeeding_____Breastmilk/formula_____

Asthma	Yes	No	Behavioral Issues	Yes	No
Developmental Issues	Yes	No	Hospitalizations	Yes	No
Psychiatric Illness	Yes	No	Seizures	Yes	No

Other_____
_____

Past Surgical History

Adenoidectomy	Yes	No	Appendectomy	Yes	No
Circumcision	Yes	No	Eye Surgery for Strabismus	Yes	No
Myringotomy Ear Tube(s)	Yes	No	Tonsillectomy	Yes	No

Other_____

Allergy:
Medications_____Foods_____Environmental_____

Family Medical History:
Adopted Yes____ No_____

Family History of Allergies	Yes	No	Family History of Asthma	Yes	No
Family History of Cancer	Yes	No	Family History of Diabetes	Yes	No
Family History of Eczema	Yes	No			

Family History of Heart Disease/High Cholesterol Yes No
Other_____

Social History:
Stay at home with family member_____ Childcare In Home Setting _____Daycare____
Participates in Competitive Sports Yes___ No___
School: Grade_____ Home School_____

PHARMACY REFERENCE_____PHONE_____