McMurray Pediatric & Adolescent Medicine, PC
Patient and Vaccination Registration Form

Please Print

Patient Information

Child's Name: Last, First, Middle Initial			Sex	Age	Birthdate
Address:			SS#		Home phone:
City:	State:	Zip	Resonsible parent/guardian		

Parent/Guardian Information

Father's/Guardian's Name		Mother's/Guardian's Name	Maiden name
Address(if different from patient's)		Address(if different from patient's)	
Birthdate	SS#	Birthdate	SS#
Home Phone(if different from patient's)		Home Phone(if different from patient's)	
Employer	Occupation	Employer	Occupation
Work Phone		Work Phone	

Vaccine Information for Registry

Birth state or country	Language(s)

Race (please circle all that apply) Aleut, Arabian, Asian Indian, Black, Cambodian, Chinese, Eskimo, Filipino, Guamian, Hawaiian, American Indian, Japanese, Korean, Laotian, Other Asian or Pacific, Samoan, Thailander, Vietnamese, White,
Other specified: _____

Hispanic Origin(please circle) Non-hispanic, Cuban, Mexican, Pueto Rican, South/Central America includes: Argentina, Belize, Bolivia, Brazil, Chile, Columbia, Costa Rica, Ecuador, El Salvador, French Guiana, Guatemala, Guyana, Honduras, Nicaragua Panama, Parguay, Peru, Suriname, Uraguay, Venezuela)
Other(please specify):_____

School District

IN CASE OF EMERGENCY, please provide us with the NAME & PHONE of the nearest relative not living with you:

Were you referred to our practice? _____By whom?_____

If not, how did you hear about our practice? _____

If applicable, who saw your child pre previously?_____

I hereby authorize McMurray Pediatric & Adolescent Medicine to release any part of the medical chart required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to co-insurance, co-payment, deductible, non-covered services. _____

Patient Questionnaire

Please check yes/no or explain where required. N/A-Not applicable

Previous doctor: Dental care (y) (n) Eye Exam (y) (n)

Pregnancy & Birth

Mother's age at pregnancy?_____

Any illness during pregnancy?_____

Medications during pregnancy?_____

(excluding vitamins/iron)

Smoking-alcohol or street drugs during? _____

Was baby late, early, or on time?_____

Vaginal or c-section?_____ Birth wt_____) Length____

Any complications?_____

Problems with baby at birth? Breathing (y) (n) Jaundice (y) (n)

Other_____

Past Medical History:

Allergic reactions? Medicine(y) (n) Food(y) (n) Animals (y) (n)

insect bites (y) (n)

Medications on a regular basis?

Immunizations? (y) (n) Do you have a record? (y) (n)

Hospitalizations?_____

_____ _____

Serious injuries?_____

_____

Anemia (y) (n) Asthma/wheezing (y) (n) Chicken pox (y) (n)

Hepatitis (y) (n) Bleeding issues (y) (n) Scarlet Fever (y) (n)

Seizure (y) (n) Blood tranfusions (y) (n) Eczema/Hive (y) (n)

Recurrent infections (3 or more) Ear (y) (n) Throat (y) (n)

Problems with hearing? (y) (n) vision (y) (n)

Other?_____

Feeding & nutrition

Colic or feeding problems during first 3 months? (y) (n)

Breast fed (y) (n) Number of months?_____

Formula? (y) (n) Current brand?_____

Vitamins? (y) (n) Brand?_____Fluoride (y) (n)

Special diet?

Family Profile

Parents- Married? ( ) Separated?( ) Divorced? () Living together?( )

Father's age?___ Health?_____

Mother's age?___Health?_____

List child's siblings & ages_____

_____

Smoking in house? (y) (n) Alcohol in house? (y) (n)

Gun in house? (y) (n) Pets? (y) (n)

Family Medical History:

List all blood relatives of your child who have the following :

Use abbreviations: (F) father (M) mother, (B) brother, (S) sister, (MM) mother's mother, (MF) mother's father, (FM) father's mother, (FF) father's father, (A) aunt, (U) uncle, (C) cousin

Family Medical History continued:

Anemia/ Blood disorder_____ Epilepsy/seizures_____

asthma_____Heart Disease_____

Mental retardation_____ High blood pressure_____

Drug problems_____ Alcoholism_____

Cancer_____Psychological issues_____

Cholesterol problems_____ADHD_____

AIDS_____Hepatitis_____

Cystic fibrosis_____Migraines_____

Musc. Dystrophy_____Sudden Infant Death_____

Tuberculosis_____Birth Defects_____

Early Deafness_____Arthritis_____

Diabetes_____Abuse of any kind_____

Other_____

Development & Behavior: Age at which:

Sat alone_____ Walked_____ Used Sentences_____

Toilet trained_____Bicycled_____

Grade in school_____

Learning problems?_____

Getting along with other children?_____

behavior problems?_____

Bedwetting? (y) (n) Sleeping (y) (n)

Any obsessive or repetitive behavior?_____

_____

Hobbies-sports- social activities?_____

Use of illegal drugs? Smoking?_____

Any concerns?_____

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Signature of person completing form

_____

relationship to child