Minidoka Medical Center RHC

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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name_____
First MI Last
Date of Birth _____/_____/_____ **SSN**_____ **Male** _____ **Female** _____

Physical Address _____**City**_____ **State**_____
Zip_____

Mailing Address _____**City**_____ **State**_____
Zip_____

Home Phone _____ **Cell Phone**_____

Email address _____ **Patient Portal Yes□ No□**

If minor child list name of parent/head of household _____

Parent/guarantor date of birth: _____**Phone number if different**_____

Patients or Parents Employer _____ **Work Phone** _____

Person to contact in case of emergency? _____ **Phone** _____
Relationship to patient: _____

Person who can call and receive patient medical information: (for confidentiality purposes)
Name: Relationship: Phone:
_____ _____ _____

_____ _____ _____

Primary Insurance _____
Name of Insured _____ **Birth-date of Insured** _____
Relationship to pt. _____**SSN of insured:** _____
ID Number _____**Group #** _____
Amount of deductible $_____ **or Co-Pay** _____

Secondary Insurance _____ **Relationship to pt.** _____
Name of Insured _____ **Birth-date of Insured** _____
Relationship to pt. _____**SSN of insured:** _____
ID Number _____**Group #** _____

Amount of deductible $_____ **or Co-Pay** _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor
X_____ **Date** _____
Signature of patient or parent if minor

Child's Name _____**Child's Date of Birth**_____ **Current age** _____
What is the child's sex? ☐ Female ☐ Male
Is your child adopted? ☐ No ☐ Yes If yes, at what age? _____
The child's parents are:
☐ Single ☐ Married ☐ Divorced ☐ Separated but not divorced
☐ Widowed ☐ Living together but not married

List your child's main health problems (or reasons for visiting the clinic).
☐ Routine checkup
☐ Immunizations (shots)
☐ A health problem (please specify)_____
☐ Switching doctors (last doctor _____)

How well do you feel your child acts or behaves?
☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Has your child ever been a patient in a hospital (please include surgeries)?
☐ No
☐ Yes (If yes, explain why and when below.)

My child was in the hospital because:	**When**

Is your child taking any prescription medicines?
☐ Yes - Please list the child's medicines below or ☐ I brought my child's medicines.
☐ No. My child does not take any prescription medicines.

Name of medicine	**Dosage**	**How many pills or doses does your child take at**
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

What pharmacy do you use for your child? _____
What over-the-counter medicines, does your child take regularly?
☐ Vitamins
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None. My child does not take any over-the-counter medicines regularly.

Does your child have any allergic reaction (bad effect) from any of the following? (Check all that apply.)
☐ Outside or Indoor allergies (for example: grass, pollen, cats …)
☐ Food Allergies (for example: peanuts, milk, wheat …)
☐ Medicine or shots (immunization). (Please list below.)
☐ No, my child has no allergies that I know of.

Medicine child is allergic to	**What happened when your child took the medicine?**

Please list the previous Medical Providers your child has seen_____
_____

Please check any of the following medical problems that your child has ever had.

Ear infections	☐Yes ☐ No
Nose problems (sinus infections, nose bleeds)	☐Yes ☐ No
Eye problems (blurry vision, wears glasses)	☐Yes ☐ No
Hearing problems	☐Yes ☐ No
Mouth or throat problems (Strep throat, swallowing problems)	☐Yes ☐ No
Diarrhea (having frequent and runny bowel movements)	☐Yes ☐ No
Constipation (problems having a bowel movement)	☐Yes ☐ No
Vomiting	☐Yes ☐ No
Problems **urinating** (bed wetting, pain when urinating)	☐Yes ☐ No
Back problems (crooked back, back pain)	☐Yes ☐ No
Growing pains (bone or body pains due to growing)	☐Yes ☐ No
Muscle and bone problems (weak muscles, pain in joints)	☐Yes ☐ No
Skin problems (acne, flaking skin, rashes, hives)	☐Yes ☐ No

Seizures	☐Yes ☐ No
ADD/ADHD (problems paying attention, sitting still)	☐Yes ☐ No
Sleeping problems (falling or staying asleep)	☐Yes ☐ No
Breathing problems (cough, asthma)	☐Yes ☐ No
Warts	☐Yes ☐ No
Jaundice (yellow skin)	☐Yes ☐ No

Has your child received immunizations (shots) in the past?
☐Yes
☐No

Does anyone in the household smoke?
☐Yes
☐No

The following questions are about the mother of the child during pregnancy and birth.

Were any of the following used during pregnancy?
☐ Cigarettes
☐ Alcohol
☐ Illegal drugs (which ones? _____)
☐ Prescription drugs (which ones? _____)
☐ None of the above

Did the mother have any of the following conditions or problems during pregnancy?
☐ Preeclampsia (high blood pressure) ☐ Diabetes (sugar)
☐ Emotional stress ☐ Injury or serious illness
☐ Unexpected bleeding or spotting ☐ Other _____

Was the birth:
☐ On the due date
☐ Before the due date (by how much_____)
☐ After the due date (by how much_____)

Was the birth: ☐ Vaginal ☐ C-Section

Were any of the following used?
☐ Pain medicine during birth (epidural)
☐ Tool to help pull baby out (forceps or vacuum)
☐ None

Were there any problems during the birth? ☐ Yes ☐ No
If yes, please explain: _____

Was/is the child breastfed? Yes ☐ No ☐ If yes, how long_____

In the first 2 months after birth, did the child have:
☐ Jaundice (yellow skin)
☐ Colic (upset stomach, crying)
☐ Breathing problems
☐ Other _____
☐ None of the above

At what age did the child begin to crawl? _____
At what age did the child begin to sit up? _____
At what age did the child begin to walk? _____
At what age did the child get his/her first tooth? _____
At what age did the child began to say words (mama, dada)? _____

How would you rate your child's health in his or her first year of life?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Does the child go to school or daycare? ☐ Yes ☐ No If yes, what is its name?

_____

If your child goes to school or daycare, describe how your child acts in school or daycare.
Check all that apply.
☐ Nervous, worried ☐ Shy, withdrawn, keeps to self
☐ Hyper, restless, can't sit still ☐ Gets angry easily
☐ Pushy, bullies others ☐ Scared, fearful
☐ Relaxed, calm ☐ Moody
☐ Social, friendly ☐ Happy

How are your child's grades in school?

☐ Excellent ☐ OK ☐ Poor ☐ Does not go to school

About how much exercise does your child get every day?
☐ Less than 30 minutes ☐ 30 minutes to 1 hour ☐ Over 1 hour

About how many hours of TV does your child watch every day?
☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

About how many hours is your child on a computer every day?
☐ Less than 1 hour ☐ 1-3 hours ☐ More than 3 hours

About how many hours does your child spend outside every day?
☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

About how many hours are spent reading with your child every day?
☐ Less than 15 minutes ☐ 15-30 minutes ☐ 30 minutes to1 hour ☐ More than 1 hour

Does your child wear a helmet when riding a bike, roller blading, skate boarding, etc?
☐ Yes ☐ No

Does your child get buckled in a car seat or wear a seat belt when riding in a car? ☐ Yes ☐ No

Do you have guns in the home? Yes ☐ No ☐
If yes, are they safely locked up? Yes ☐ No ☐

What activities is your child involved in:_____
_____
☐ Too young to be involved in activities

Please list what your child typically eats and drinks in a day: _____
_____
_____

Check all the people that the child lives with:
☐ Mother
☐ Father
☐ Brothers (how many?_____)
☐ Sisters (how many?_____)
☐ Other family members (list _____)
☐ Friends or other people (list_____)
☐ Animals ☐ Dogs (how many?_____) ☐ Cats (how many?_____)
☐ Other animals _____

What medical problems do people in the child's family have?

Family Member	Medical Problems
Parents:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems ☐ Other: _____
Siblings:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems ☐ Other: _____