



Santa Cruz Women's Health Center, 250 Locust St. Santa Cruz, California 95060 T. 831.427.3500

Initial Pediatric History Birth to 4 mos.

Child's Name: _____ Male Female
Guardian's Name(s):: _____ Child's Date of Birth: _____

Birth History

Birth Weight: _____ lbs _____ oz Type of delivery, circle one : Vaginal C-Section

Was your baby born on time (40 weeks) Early Late?

If late or early, how many days? _____

Was your prenatal care done at SCWHC? Yes No

If not, where? _____

Was your baby born in a hospital? Yes No

Were there any pregnancy complication? _____

Were there any problems in the hospital? _____

Was the baby adopted? No Yes

Prenatal History

During pregnancy, did mother:

Smoke No Yes If yes, how much? _____

Use alcohol/drugs No Yes If yes, what, how much & how often? _____

Take any medication No Yes If yes, explain _____

Is the baby's mother currently taking any medications or vitamins? No Yes

If so, please list: _____

Social History

Does your child have brothers and sisters? Please list their names and dates of birth:

Who lives in the house? Please list names and relationship to your child:

Family History

Has this child's parents, grandparents, aunts, uncles, brothers, or sisters had any of the illnesses listed below? Also let us know if it is on the mother or the father's side of the family.

- | | |
|---|----------------------------------|
| Alcohol / drug abuse _____ | High cholesterol _____ |
| Anemia (severe) _____ | High blood pressure _____ |
| Arthritis _____ | Kidney problems _____ |
| Asthma _____ | Mental illness/retardation _____ |
| Cancer (Type: _____) _____ | Seizures _____ |
| Diabetes _____ | Thyroid disorder _____ |
| Eczema _____ | Tuberculosis/lung disease _____ |
| Heart Disease _____ | Other _____ |
| Tay-Sachs/ cystic fibrosis/ or sickle cell anemia _____ | |

Are both parents of your child in good health? Yes No

If no, please explain _____

Are both parents of your child involved with the family? Yes No

Your last medical provider was: _____

Signature of Parent/Guardian: _____

History reviewed by: _____ **Date:** _____



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Initial Pediatric History 5 mos to 5 years

Child's name: _____ Male Female

Guardian's name: _____ Child's DOB: _____

Child's birth weight: _____ lbs _____ oz

SOCIAL HISTORY

Does your child have brothers and sisters? Please list their names and dates of birth:

Who lives in the house? Please list names and relationship to your child:

PRENATAL HISTORY

During pregnancy, did mother:

Smoke No Yes If yes, how much? _____

Use alcohol/drugs No Yes If yes, what, how much & how often? _____

Take any medication No Yes If yes, explain _____

Were there any complications with the pregnancy or birth? No Yes If yes, explain _____

MEDICAL HISTORY

Has the child been hospitalized? Yes No If yes, explain _____

Has your child had any surgery? Yes No If yes, explain _____

Has your child ever had:

Anemia Yes No Ear infections Yes No

Asthma Yes No Eczema/hives Yes No

Hay fever/allergies Yes No Pneumonia Yes No

Convulsions Yes No Hearing problems Yes No

Diabetes Yes No Heart murmur Yes No

Reaction to immunization Yes No Explain _____

Other medical problems Yes No Explain _____

Serious injuries Yes No Explain _____

Does your child currently have:

Diarrhea Yes No

Constipation Yes No

QUESTIONS CONTINUED ON THE BACK

Nutrition:

Is the child being breast-fed now? Yes No

If no, was the child ever breast-fed? Yes No

Family History

Has this child's parents, grandparents, aunts, uncles, brothers, or sisters had any of the illnesses listed below? If so, please circle the illness and say who in the family has this.

- | | |
|---|----------------------------------|
| Alcohol / drug abuse _____ | High cholesterol _____ |
| Anemia (severe) _____ | High blood pressure _____ |
| Arthritis _____ | Kidney problems _____ |
| Asthma _____ | Mental illness/retardation _____ |
| Cancer (Type: _____) _____ | Seizures _____ |
| Diabetes _____ | Thyroid disorder _____ |
| Eczema _____ | Tuberculosis/lung disease _____ |
| Heart Disease _____ | Other _____ |
| Tay-Sachs/ cystic fibrosis/ or sickle cell anemia _____ | |

Are both parents of your child in good health? Yes No

If no, please explain _____

Are both parents of your child involved with the family? Yes No

Your last medical provider was: _____

Signature of Parent/Guardian: _____

History reviewed by: _____ **Date:** _____



Santa Cruz Women's Health Center, 250 Locust St. Santa Cruz, California 95060 T. 831.427.3500

Initial Pediatric History 6 to 20 years

Child's Name: _____ Male Female

Guardian's Name(s): _____ Child's DOB: _____

Current Medications or supplements?

(List): _____

Allergies? (List): _____

MEDICAL HISTORY

Were there any serious complications with the pregnancy or birth? No Yes

If yes, explain _____

Has the child been hospitalized? No Yes If yes, please explain _____

Has your child had any surgery? No Yes If yes, please explain _____

Has your child ever had:

Anemia No Yes Ear infections No Yes

Asthma No Yes Eczema/hives No Yes

Hay fever/allergies No Yes Pneumonia No Yes

Convulsions No Yes Hearing problems No Yes

Diabetes No Yes Heart murmur No Yes

Frequent urinary tract infections Yes No

Reaction to immunization Yes No Explain _____

Other medical problems Yes No Explain _____

Serious injuries Yes No Explain _____

Does your child currently have:

Diarrhea No Yes

Constipation No Yes

QUESTIONS CONTINUED ON THE BACK

Family History

Has this child's parents, grandparents, aunts, uncles, brothers, or sisters had any of the illnesses listed below? If so, please circle the illness and say who in the family has this.

- | | |
|---|----------------------------------|
| Alcohol / drug abuse _____ | High cholesterol _____ |
| Anemia (severe) _____ | High blood pressure _____ |
| Arthritis _____ | Kidney problems _____ |
| Asthma _____ | Mental illness/retardation _____ |
| Cancer (Type: _____) | Seizures _____ |
| Diabetes _____ | Thyroid disorder _____ |
| Eczema _____ | Tuberculosis/lung disease _____ |
| Heart Disease _____ | Other _____ |
| Tay-Sachs/ cystic fibrosis/ or sickle cell anemia _____ | |

Are both parents of your child in good health? Yes No

If no, please explain _____

Are both parents of your child involved with the family? Yes No

Your last medical provider was: _____

SOCIAL HISTORY/ SCHOOL HISTORY

Does your child have brothers and sisters? Please list their names and dates of birth:

Who lives in the house? Please list names and relationship to your child:

If in school: Year in School _____ School name: _____

Signature of Parent/Guardian: _____

History reviewed by: _____ **Date:** _____



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Consent To and Direction for Treatment of Minor

Minor Name: _____ D.O.B.: _____

Parent(s) Name: _____

I, (We), being the parent(s) or guardian(s) of the aforesaid minor, do hereby authorize, request and direct the Santa Cruz Women's Health Center to provide/perform such treatment to said minor as in your judgment is advisable. I understand that all treatments or diagnostic measures will be explained at the time of the exam or procedure.

The above minor may from time to time appear at the Santa Cruz Women's Health Center for examination or treatment, or both, unaccompanied by an adult, because of my (our) absence or unavailability.

I, (We), understand that the physicians, nurses, or administrators may consider it advisable that a parent or guardian or other adult be present with said minor for the purpose of assisting in the diagnosis or treatment. I, (We), agree to cooperate by being present with said minor at all times possible or when requested.

I give my consent for my child to be attended by a physician assistant, a nurse practitioner or physician. Physician assistants and nurse practitioners are certified and licensed to provide care under the supervision of a physician.

Signature: _____

Date: _____

Specify Relationship to Minor: _____

The following other adult has my permission to accompany my child to medical visits and make medical decisions for my child:

Name: _____ Relationship: _____ Phone: _____

Emergency contact:

Name: _____

Relationship to minor: _____ Day/Evening Phone: _____

Parent Consent for the Use and Disclosure of Health Information

The Santa Cruz Women's Health Center is committed to treating and using protected health information about your child responsibly by obeying laws on how we use and share your child's information. We are required to obtain your consent for the use and disclosure of health information:

I give my consent to the Santa Cruz Women's Health Center to use and disclose my child's health information for treatment, payment, and health care operations.

I acknowledge that I have been advised of my right to:

- *Review the SCWHC Privacy Notice*
- *Request restrictions on how information is used and disclosed for treatment, payment and health care operations purposes*
- *Revoke consent*

I acknowledge that I have received the Notice of Privacy Practices of the Santa Cruz Women's Health Center and I have been provided an opportunity to review it.

Parent or Legal Guardian _____ signature _____ Date: _____