

Santa Cruz Women's Health Center

**Pediatric Initial History
Birth to 5 Years**

Child's Name: _____ Male Female
Guardian's Name(s): _____ Child's DOB: _____
Allergies? (List): _____
Current Medications? (List): _____

Birth History

Birth Weight: _____ lbs _____ oz Type of delivery: Vaginal _____ C-Section: _____
Was your baby born early or late? (circle one) How many days? _____
Was your baby born in a hospital? Yes No If yes, which hospital? _____
Were there any problems in the hospital? _____

Prenatal History

Did mother have prenatal care? Yes No If yes, which month did care begin? _____

During pregnancy, did mother have:

- | | | |
|-----------------------------------|------------------------------|---|
| any serious illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| high blood pressure/pre-eclampsia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| German measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a serious accident | <input type="checkbox"/> Yes | <input type="checkbox"/> No If yes, explain _____ |
| pelvic infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No If yes, explain _____ |
| surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No If yes, explain _____ |
| other prenatal complications | <input type="checkbox"/> Yes | <input type="checkbox"/> No If yes, explain _____ |

During pregnancy, did mother:

- | | | | |
|---------------------|------------------------------|-----------------------------|-------------------------------------|
| smoke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how much? _____ |
| use alcohol/drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how much & how often? _____ |
| take any medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, explain _____ |

At birth and immediately after, did baby have:

- | | | | | | |
|--------------------------|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|
| delayed breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | need for oxygen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| meconium | <input type="checkbox"/> Yes | <input type="checkbox"/> No | blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| spinal tap or antibiotic | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Dental

Has your child had a dental exam? Yes No Date of last visit: _____

PLEASE COMPLETE BACK OF FORM ALSO

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 eczema/hives Yes No

asthma Yes No hay fever/allergies Yes No

constipation Yes No hearing problems Yes No

convulsions Yes No heart murmur Yes No

diabetes Yes No pneumonia Yes No

diarrhea Yes No ear infections Yes No

reaction to immunization Yes No Explain _____

other medical problems Yes No Explain _____

serious injuries Yes No Explain _____

Growth and Development

Is the child being breast-fed now? Yes No Was the child ever breast-fed? Yes No

At what age did your child:

-sit alone? _____

-roll? _____

-walk? _____

-get first teeth? _____

-talk (2-word sentences)? _____

-toilet trained? Day: _____ Night: _____

Family History

Has this child's parents, brothers, or sisters had:

alcohol drug abuse Yes No high blood pressure Yes No

anemia (severe) Yes No high cholesterol Yes No

arthritis Yes No kidney problems Yes No

asthma Yes No mental illness/retardation Yes No

cancer (Type: _____) Yes No seizures Yes No

cystic fibrosis Yes No Tay-Sachs Yes No

diabetes Yes No thyroid disorder Yes No

eczema Yes No tuberculosis/lung disease Yes No

heart disease Yes No other _____

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

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

Your last doctor was _____

Signature of Parent/Guardian: _____

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

Santa Cruz Women's Health Center

**Pediatric Initial History
6 to 20 Years**

Child's Name: _____ Male Female
Guardian's Name(s): _____ Child's DOB: _____
Allergies? (List): _____
Current Medications? (List): _____
Taking Vitamins? Y N Taking Fluoride? Y N

Birth History

Any serious problems with mother's pregnancy or child's birth? Y N
Explain: _____

School History

Year in school: _____ School name: _____
School problems?: _____
Discipline or behavior problems?: _____
Ever seen a Psychologist, speech therapist or special teacher? Y N
Regular attendance? Y N

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	eczema/hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	hay fever/allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
broken bones	<input type="checkbox"/> Yes <input type="checkbox"/> No	tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No

urinary tract infection Yes No
reaction to immunization Yes No Explain _____
other medical problems Yes No Explain _____
serious injuries Yes No Explain _____
Other medical problems? _____

PLEASE COMPLETE BACK OF FORM ALSO

Dental

Date of last visit: _____

Family History

Has this child's parents, brothers, or sisters had (✓ if yes)

- | | |
|--|---|
| <input type="checkbox"/> alcohol drug abuse? | <input type="checkbox"/> high blood pressure? |
| <input type="checkbox"/> anemia (severe)? | <input type="checkbox"/> high cholesterol? |
| <input type="checkbox"/> arthritis? | <input type="checkbox"/> kidney problems? |
| <input type="checkbox"/> asthma? | <input type="checkbox"/> mental illness/retardation? |
| <input type="checkbox"/> cancer? (Type: _____) | <input type="checkbox"/> seizures? |
| <input type="checkbox"/> cystic fibrosis? | <input type="checkbox"/> Tay-Sachs? |
| <input type="checkbox"/> diabetes? | <input type="checkbox"/> thyroid disorder? |
| <input type="checkbox"/> eczema? | <input type="checkbox"/> tuberculosis/other lung disease? |
| <input type="checkbox"/> heart disease? | <input type="checkbox"/> other _____ |

Names and ages of brothers & sisters (start with the oldest):

Name: _____ Age: _____ Heath Problem(s)? _____
 Name: _____ Age: _____ Heath Problem(s)? _____
 Name: _____ Age: _____ Heath Problem(s)? _____

- Are both parents of this child in good health?
 Are both parents of this child involved with the family?

Your last doctor was _____

For GIRLS Only

Age when period began: _____

Periods are:

- Regular Painful Moderate
 Irregular Light Heavy

Periods come every _____ days and lasts _____ days.

Is there bleeding between periods?

- Yes No Sometimes

When was the 1st day of the girl's last period? _____

Was it normal? Yes No

Client Education

Would you like more information about:

- Smoking? Y N
 Alcohol? Y N
 Drugs? Y N
 Sex? Y N
 Contraception Y N
 HIV/AIDS? Y N
 Sexually transmitted infections? Y N

Signature of Parent/Guardian: _____

Name of Child: _____ **Date:** _____

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



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

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: _____