Kid Kare Pediatrics

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Child’s Name*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* DOB*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: wellness exam Sick visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Neonatal History |
| Type of delivery: Vaginal C-section Prenatal Ultrasound: Normal Abnormal: If ultrasound was abnormal during pregnancy then please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did you have any complications during the pregnancy? No Yes: list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Which hospital was the baby born at: Beaumont Hospital Garden City Hospital Children Hospital Henry Ford Hospital Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was baby born premature? No Yes, How many weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was baby Breech: No Yes Did baby receive Hepatitis B vaccine at the Hospital: No Yes Did your baby pass newborn hearing test? Left Ear: pass fail Right Ear: pass failMother ‘s labs done during pregnancy: Maternal Hepatitis B:  Negative Positive; Maternal Group B strep: Negative Positive (If positive: Was mother treated with antibiotics: No Yes  |

Child Immunizations up to date? No Yes

Is your child on a special diet? No Yes

Does the child live with pets? No Yes

Does anyone smoke in the home? No Yes

Does the child attend daycare/school? No Yes

Is the child in foster care? No Yes

Is your child taking any medications or drugs? No Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Pharmacy do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? No Yes, Why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ Has your child ever had surgery? No Yes, Why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

Have you or child’s physician had any concerns with developmental delays (i.e., speech, motor skills, etc.) No Yes

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Medication Allergies: None (No known drug allergies) Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: No Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Child and Family History |
| Child Family Child Family Anemia Hypertension Asthma Hearing problems ADD/ADHD Arthritis Bed Wetting Kidney Disease Bladder Infection/UTI Lead Poisoning Bleeding Disorder Liver Disease Birth Defects Allergic rhinitis Cancer Pneumonia Constipation Tobacco Exposure Cerebral Palsy Speech Problems Colitis Sinus Problems Depression Strep Throat  Diabetes Tuberculosis Drug/Alcohol Abuse Thyroid Problems Ear Infections #\_\_\_\_\_\_ Vision Problems Eczema Kidney Reflux G.E.R.D. (Reflux) Heart disease |

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| Social History |
| Parents: Married Divorced Separated Single  |
| Persons living in the house: Father Mother Brothers\_\_\_\_ Sisters\_\_\_\_ Grandmother Grandfather Aunt Uncle Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

List the names & ages of the people the child lives with:

 *NAME AGE RELATIONSHIP TO CHILD*

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The information that I have given is correct of the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child’s medial status.

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Signature of Parent or Guardian Date