Northside Cherokee
PEDIATRICS

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# PATIENT MEDICAL HISTORY

**Name** _____ **Date of Birth** ____/____/____ **Date** _____

Person Completing Form _____ Relationship _____

## SOCIAL HISTORY

**Who lives in the child's home?**

Name _____ Age _____ Occupation _____
Name _____ Age _____ Occupation _____
Name _____ Age _____ Occupation _____
Name _____ Age _____ Occupation _____
Name _____ Age _____ Occupation _____
Name _____ Age _____ Occupation _____

**Does anyone smoke?** ☐ Inside ☐ Outside ☐ None **What kind of water does your child drink?** ☐ Well ☐ City ☐ Bottled

**School/Day Care Provider** _____

**Do you have any pets?** ☐ Yes ☐ No If so, what kind? _____

## BIRTH HISTORY

**Where was the child born?** ☐ Home ☐ Hospital ☐ Other _____

**Length of pregnancy?** _____ **Length of labor?** _____

**Delivery type?** ☐ Vaginal ☐ C-Section **Days in hospital?** _____ **NICU?** ☐ Yes ☐ No

**If in NICU, list reasons why:** _____

**Birth Weight** _____ **Birth Length** _____

**Problems at or soon after birth:**

Jaundice ☐ Yes ☐ No ☐ Unknown
Birth Defects ☐ Yes ☐ No ☐ Unknown
Breathing Problems ☐ Yes ☐ No ☐ Unknown
Was the newborn screen ("PKU") done? ☐ Yes ☐ No ☐ Unknown
Any problems with the PKU? _____

## DEVELOPMENTAL HISTORY

**Please list the age at which this child:**

Started cooing _____ Sat without help _____ Started to say words _____

Pulled up on furniture _____ Started to walk _____

## HEALTH HISTORY

**Allergies** _____

_____

_____

_____

**Current Medications** _____

_____

_____



## MEDICAL HISTORY

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**Patient Name** _____ **Date of Birth** _____/_____/ _____

**Past/Chronic Medical problems (Example: Asthma, kidney infections, cerebral palsy):** _____

## SURGICAL HISTORY

**Surgery** _____

## HOSPITALIZATIONS

**Reason** _____

**Reason** _____

**Reason** _____

**Reason** _____

**Reason** _____

## FAMILY HISTORY

**Indicate who has had the problem:** M = mother, F = father, C = child, S = sister, B = brother, MGF/MGM = maternal grandfather/grandmother, PGF/PGM = paternal grandfather/grandmother, MA/MU = maternal aunt/uncle, PA/PU = paternal aunt/uncle

- ☐ Allergies/Hay fever
- ☐ Ear infections
- ☐ Hearing loss (childhood)
- ☐ Vision problems
- ☐ Strep throat
- ☐ Sinus problems
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack (give age)
- ☐ Asthma/bronchitis
- ☐ Cystic fibrosis
- ☐ Tuberculosis (TB)
- ☐ Stomach or intestinal problems
- ☐ Liver disease
- ☐ Bladder or kidney infections
- ☐ Kidney reflux
  - ☐ Other kidney problems
  - ☐ Birth defects
  - ☐ Anemia/blood disorder
  - ☐ Cancer
  - ☐ Diabetes
  - ☐ Thyroid problems
  - ☐ Growth problems
  - ☐ Seizures
  - ☐ Migraines
  - ☐ Alcohol or drug abuse
  - ☐ Depression/anxiety or other psychiatric problems
  - ☐ ADHD, learning problems
  - ☐ Mental retardation
  - ☐ Other



## MEDICAL HISTORY

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Patient Name: _____ Patient DOB _____

I understand that my child's doctor recommends that my child receive immunizations as per the Center for Disease Control (CDC) immunization schedule, and American Academy of Pediatrics guidelines.

I understand that I will be given a Vaccine Information Sheet (VIS) from the CDC for each vaccine before it is administered and I will be given the opportunity to ask questions. The VIS explains the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's doctor or nurse, who will answer my questions regarding the recommended vaccine(s), and provide the following information:

- The purpose of and the need for the recommended vaccine(s)
- The risks and benefits of the recommended vaccine(s)
- The consequences if my child does not receive the vaccine(s), which may include:
  - contracting the illness the vaccine should prevent. (The outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable disease are possible as well~)
  - transmitting the disease to others (including those too young to be vaccinated or those with immune problems)
  - requiring my child to stay out of child care or school during disease outbreaks
- My child's doctor or nurse, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control all strongly recommend that these vaccines be given according to recommendations.

I understand that by signing this form, I give consent for my child to receive recommended immunizations per the CDC Immunization Schedule, including the influenza vaccine with the exception of any immunizations refused below. While I will be given specific information for each immunization, I will not need to sign individual consents for each vaccine. This consent will be reviewed each year. I understand that I may address this issue with my child's doctor or nurse at any time and that I may re-visit decisions on immunization for my child anytime in the future.

I consent to Northside Hospital, through its agents or employees, including my child's doctor(s) and nurse(s) administering the recommended immunizations per the CDC schedule. I release Northside Hospital and its agents and employees from any and all liabilities in connection with the vaccines and the administration to my child. I acknowledge that no guarantee or assurance has been made to me concerning the results that may be obtained from the administration of the vaccines.

NORTHSIDE HOSPITAL, BY ADMINISTERING THE VACCINES TO MY CHILD PROVIDES NO WARRANTY WITH RESPECT TO THE VACCINES AND SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE CONCERNING THE VACCINES.

Georgia law requires health care providers to report all vaccinations to the Georgia Registry of Immunization Transactions and Services (GRITS). Patients are deemed to consent to reporting unless they have submitted a written request to "opt out" to the Georgia Department of Public Health.

☐ I represent that I have filed an "opt out" request with the Georgia Department of Public Health.
☐ I acknowledge that I have read this document in its entirety and all of my questions have been answered.

_____ _____
Parent/Guardian Date/time Witness Date/Time

_____
Interpreter (if applicable)
Telephone interpretation provided,
record name of company and interpreter ID number

REFUSAL OF IMMUNIZATION

I refuse to consent to administration of the following vaccine(s) which have been recommended by my child's doctor or nurse. I have received the Vaccine Information Sheet and understand the possible consequences of refusing the vaccine(s). I release Northside Hospital and its agents and employees from any and all liabilities in connection with my refusal to allow administration of the indicated vaccine(s) to my child.

☐ Refuse all vaccines ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____

_____ _____
Parent/Guardian Date/time Witness Date/Time

_____
Interpreter (if applicable)
Telephone interpretation provided,
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# ANNUAL IMMUNIZATION CONSENT FORM

# NORTHSIDE HOSPITAL

**Northside Cherokee Pediatrics**

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

I am the parent or legal guardian of the minor child/children identified below:

| Name | Date of Birth |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

In case of my absence or unavailability, I authorize the following individuals to consent to medical treatment of the child/children named above at the Northside Hospital Affiliated Medical Practice (the "Practice"):

| Name of authorized representative | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I agree that I will be financially responsible for and guarantee payment of any and all charges incurred in connection with the rendering of care to my child with the consent of one of the above named individuals.

I understand that health care providers at the Practice may disclose to the authorized individual appropriate information about my child's treatment or condition, such as discharge instructions and information about medication prescribed during that visit.

This authorization will remain in effect until I notify the Practice in writing that I wish to revoke or replace the form.

_____ _____

Signature of parent/legal guardian | Witness Date/ time

[Two witnesses required if verbal/telephone consent]

_____ _____

Date Time | Witness Date/ time

_____

Interpreter

(Note: if phone interpretation used, record interpreter ID#)



**AUTHORIZATION TO TREAT MINOR**