Northside Cherokee
PEDIATRICS

HOLLY SPRINGS:
684 Sixes Road
Suite 130
Holly Springs, GA 30115
Ph (678) 388-5485
Fax (678) 388-5489

WOODSTOCK:
900 Towne Lake Parkway
Suite 306
Woodstock, GA 30189
Ph (770) 852-7720
Fax (770) 852-7721

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

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 _____

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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)
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ANNUAL IMMUNIZATION CONSENT FORM