Decatur County Memorial Hospital
The Quality Care You Want. Close By.
PEDIATRIC CARE

Dr. Maria Darr
718 N. Lincoln St. Suite B
Greensburg, IN 47240

PERSONAL INFORMATION

Name:_____ Phone #: _____

Address:_____

Date of Birth:_____ Sex:_____

Father's Name:_____ DOB: _____ SS #: _____

Father's Address:_____ Phone #: _____

Father's Employer:_____ Work Phone #: _____

Mother's Name:_____ DOB:_____ SS #: _____

Mother's Address:_____ Phone #: _____

Mother's Employer:_____ Work Phone #: _____

Emergency Contact:_____
Name Phone #

Siblings:

_____ _____

_____ _____

_____ _____

ASSIGNMENT & RELEASE:

I authorize my insurance benefits to be paid directly to Decatur County Pediatric Care. I also authorize Decatur County Pediatric Care to release any information required and I allow a photocopy of my signature to be used to file insurance. I am financially responsible for non-covered charges. I specifically agree that in the event of default, attorney fees, court costs, and costs of collection shall be added to the amount due on this account.

I authorize Decatur County Pediatric Care to release any medical or insurance information to process any lab work or x-ray.

I authorize the release of my medical records or request that copies of such be transferred to Decatur County Pediatric Care.

_____ _____

Signature of patient or legal guardian Date

Contact Email: _____

_____

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INITIAL HISTORY QUESTIONNAIRE

Form Completed By : _____

Initial Date Completed: _____

Date Updated: _____

Name: _____

ID Number: _____

Birthdate: ____/____/____ Age: _____

Sex: ☐ M ☐ F

GENERAL

Do you consider your child to be in good health?
☐ Yes ☐ No ☐ Explain: _____

Does your child have any special health care needs?
☐ Yes ☐ No ☐ Explain: _____

Has your child ever been hospitalized?
☐ Yes ☐ No ☐ Explain: _____

Is your child allergic to medicine or drugs?
☐ Yes ☐ No ☐ Explain: _____

BIRTH HISTORY

Birth weight _____

Was the baby at full-term? ___ OR ___weeks

Delivery: ☐Vaginal ☐Cesarean

Explain: _____

Any prenatal/neonatal complications?
☐ Yes ☐No Explain: _____

NICU required? ☐ Yes ☐No

Explain: _____

During pregnancy, did the mother:
☐ Use tobacco? ☐ Drink alcohol?
☐ Use drugs/medications? If yes, please list:

_____

Blood type: Mother _____ Baby _____

Mothers lab results: HIV? ☐Pos ☐Neg

Hepatitis B? ☐ Pos ☐Neg

Group B streptococcus? ☐Pos ☐Neg

After birth, did the baby get:
Vitamin K shot? ☐ Yes ☐No
Erythromycin eye ointment? ☐Yes ☐No
Hepatitis B Shot? ☐ Yes ☐ No

Did baby go home with mother from hospital?
☐ Yes ☐ No Explain: _____

_____

Initial feeding: ☐ Formula ☐Breastmilk

If breastmilk, how long? _____

BIOLOGICAL FAMILY HISTORY

Have any family members had (if yes, check the box and specify who on the line):

- ☐ Anemia/bleeding problems _____
- ☐ Asthma _____
- ☐ Allergies _____
- ☐ Alcohol use problems _____
- ☐ Bed-wetting (after age 10) _____
- ☐ Cancer (before age 55) _____
- ☐ Childhood hearing loss _____
- ☐ Dental decay or multiple cavities _____
- ☐ Kidney Disease _____
- ☐ Depression or Anxiety _____
- ☐ Developmental Disability _____
- ☐ Diabetes _____
- ☐ Heart Attack _____
- ☐ Heart Disease (before age 55) _____
- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ HIV or AIDS _____
- ☐ Tuberculosis _____
- ☐ Liver disease _____
- ☐ Mental health conditions _____
- ☐ Obesity _____
- ☐ Seizures or epilepsy _____
- ☐ Stroke _____
- ☐ Substance use problems _____
- ☐ Sudden death (before age 50) _____
- ☐ Thyroid or other endocrine disease _____
- ☐ Tobacco use problems _____
- ☐ Vision/eye problems _____

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery & Child's Age	Where Completed	Details

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PATIENT PAST HISTORY

Has your child ever had:

Eye problems, cataracts, or retinoblastoma	☐ Yes	☐ No	Explain _____
Vision impairment or concerns	☐ Yes	☐ No	Explain _____
Nasal allergies (dust, pets, or environmental)	☐ Yes	☐ No	Explain _____
Frequent ear infections	☐ Yes	☐ No	Explain _____
Hearing loss or concerns	☐ Yes	☐ No	Explain _____
Multiple cavities/teeth problems	☐ Yes	☐ No	Explain _____
Frequent colds or sore throats	☐ Yes	☐ No	Explain _____
Asthma, wheezing, or breathing problems	☐ Yes	☐ No	Explain _____
Bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain _____
Heart murmur or other heart problems	☐ Yes	☐ No	Explain _____
High blood pressure	☐ Yes	☐ No	Explain _____
Frequent stomach pain	☐ Yes	☐ No	Explain _____
Constipation needing medical treatment	☐ Yes	☐ No	Explain _____
Food allergies or intolerance	☐ Yes	☐ No	Explain _____
Feeding issues or underweight	☐ Yes	☐ No	Explain _____
Overweight or obesity	☐ Yes	☐ No	Explain _____
Urinary tract infections	☐ Yes	☐ No	Explain _____
Bed-wetting (after age 5)	☐ Yes	☐ No	Explain _____
Kidney, ureter, or bladder problems	☐ Yes	☐ No	Explain _____
Serious injuries or fractures	☐ Yes	☐ No	Explain _____
Bone, joint, or muscle problems	☐ Yes	☐ No	Explain _____
Frequent headaches or dizziness	☐ Yes	☐ No	Explain _____
Concussion or head injury	☐ Yes	☐ No	Explain _____
Convulsions, seizures, or neurological issues	☐ Yes	☐ No	Explain _____
Sleep problems or snoring	☐ Yes	☐ No	Explain _____
Skin rashes, eczema, or hives	☐ Yes	☐ No	Explain _____
Acne	☐ Yes	☐ No	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	Explain _____
Diabetes	☐ Yes	☐ No	Explain _____
Metabolic/genetic disorders	☐ Yes	☐ No	Explain _____
Anemia or bleeding problems	☐ Yes	☐ No	Explain _____
Cancer or chemotherapy	☐ Yes	☐ No	Explain _____
Bone marrow or organ transplant	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
HIV or AIDS	☐ Yes	☐ No	Explain _____
Chickenpox or zoster (shingles)	☐ Yes	☐ No	Explain _____
Developmental delays	☐ Yes	☐ No	Explain _____
School problems or learning difficulties	☐ Yes	☐ No	Explain _____
ADHD or behavioral concerns	☐ Yes	☐ No	Explain _____
Anxiety depression, or mood problems	☐ Yes	☐ No	Explain _____
Tobacco, alcohol, or drug use	☐ Yes	☐ No	Explain _____
Exposure to family violence	☐ Yes	☐ No	Explain _____
Pregnancy or miscarriage	☐ Yes	☐ No	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	Explain _____
Females: issues with periods	☐ Yes	☐ No	Explain _____

Age of first period: _____

Other medical problems (please list): _____

_____