Northside Pediatrics, PC
Pediatric and Adolescent Medicine

Today's date: _____

You must complete this form prior to your child's visit. Please mail completed form to 3888 Northside Drive Macon, Ga. 31210, or fax it to us at (478) 477-7076 at least 10 days before your appointment.

Child's Name: _____ Date of Birth: _____ Sex: M F
Person Completing This Form: _____ Relationship to Child: _____
Primary Insurance: _____ ID: _____

I. GENERAL HISTORY

1. Does your child have any of the following symptoms/ illnesses? (Please check all that apply.)
   - ☐ GI Issues (Reflux, Ulcers, etc.) ☐ Learning/Developmental Disabilities (Autism, ADHD, etc.)
   - ☐ Asthma ☐ Heart Problems ☐ Diabetes
   - ☐ Other (Specify All)

_____

2. Does your child have any allergies? ☐ Yes ☐ No
   If yes, please indicate:

_____

3. Please describe anything else we need to know:

_____
_____
_____

II. BIRTH HISTORY

1. Was your baby born within 2 weeks of his/her due date? ☐ Yes ☐ No
   If not, at how many weeks gestation was the baby born? _____
2. How much did your baby weigh at birth? _____ Born by: __ Vaginal __ Caesarian Section
3. Did you have any of the following problems with pregnancy, labor, or delivery:
   - ☐ Gestational Diabetes ☐ Preterm Labor ☐ Eclampsia/Pre-eclampsia
   - ☐ Abnormal Ultrasound ☐ Infection ☐ Other

(Specify)_____
Please describe:

_____

4. Did your baby have any of the following problems in the nursery?
   - ☐ Gastroesophageal Reflux (GERD) ☐ Mechanical Ventilation ☐ Bronchopulmonary Dysplasia (BPD)
   - ☐ Apnea ☐ CPAP Therapy ☐ Necrotizing Enterocolitis (NEC)
   - ☐ Feeding and Growth Issues ☐ Tube Feedings ☐ Intraventricular Hemorrhage (bleeding in brain)
   - ☐ Other (Specify)

_____

5. How long did your baby stay in the NICU? _____

III. PEDIATRIC CARE

1. Previous name, address, and contact number of primary physician/ pediatrician:

_____
_____

2. Does your child currently see any specialists? □ Yes □ No - If yes, please list below:

Name of Specialist	Specialty	Location (city, state & phone #)	Date last seen

3. Please list your child's current medications. (Include vitamins and other over-the-counter medications):

Medication	Dose	How Often	Prescribing Doctor's name

4. Has your child ever been hospitalized or required surgery? □ Yes □ No

If yes, please give dates, reason, and facility name/location:

_____

5. Are your child's immunizations up to date? □ Yes □ No

Name of physician or facility immunizations given by

_____

(Please bring copy of immunization record if out of state)