BlueRidge Pediatrics

Main Office
3124 Blue Ridge Road, Suite 102
Raleigh, NC 27612
Office Number: (919) 782-0021

Brier Creek Office
10208 Cerny Street, Suite 104
Raleigh, NC 27617
Office Number: (919) 226-0662

Patient's Last Name: ________________________ **First Name:** ________________________ **Middle Initial:** ______

DOB: _____/_____/_____ **Gender: Male**____ **Female**____ **Patient Phone (***If 16 yrs. or older***):**________________________

MOTHER/LEGAL GUARDIAN	FATHER/LEGAL GUARDIAN
Name: ____	**Name:** ____
DOB: _____/_____/_____	**DOB:**_____/_____/_____
Address: ____	**Address:** ____
City State Zip	City State Zip
Home Phone: (_______)_________-_____________	**Home Phone:** (_______)_________-_____________
Work Phone: (_______)_________- _____________	**Work Phone:** (_______)_________- _____________
Cell Phone: (______)_________- _____________	**Cell Phone:** (______)_________- _____________
Email: ________________________________	**Email:** ________________________________
Marital Status: (check one)	**Marital Status:** (check one)
Single_____Married______Divorced______Widowed ______	Single_____Married______Divorced______Widowed ______

Who is the primary caregiver? Both___________ **Father**_____________**Mother**_________

Other (Please explain): ____

If applicable, who has primary custody? Both_________**Father**________**Mother**__________**Other**__________________

**(Please provide legal documentation for any alternative custody arrangements.)*

EMERGENCY CONTACT (Other Than Parent)

Name: ______________________________________ **Relationship:** ______________________________

Home Phone: (____________) ________- _____________________**Cell Phone:** (_________)_________- ______________________

INSURANCE INFORMATION

Primary Insurance Company Name: ____

Insured's ID Number: __________________________ **Group Plan Number:** ________________________________

Insured (Policy Holder) First and Last Name: ____

ADDITIONAL INFORMATION

Race: (check one) American Indian/Alaskan Native_____ Asian_____ Black/African American_____

Native Hawaiian_____ Other Pacific Islander_____ White_____ More than 1 Race_____ Declines to Respond_____

Ethnicity: (check one) Hispanic or Latino_____ Not Hispanic or Latino_____ Declines to Respond_____

Preferred Language: ____________________________

Pharmacy Name: _____________________________ **Pharmacy Address:** ____

Pharmacy Phone Number: _____________________

I hereby certify that the information above is true and accurate.

X: ____ **Date**________________________

SIGNED (Patient, or parent if under 18 years of age.)

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Initial History Questionnaire

Child's Full Name:___________________________________
Preferred Name:__________________
Form Completed by:________________relationship___________

Today's date:_____________
DOB:__________________
[ ] Male [ ] Female
Chart#:__________________

SOCIAL HISTORY Please list those living in the child's home:

Name	Relationship	Birth date	Job or School	Health Problems

Biological Parents: [ ] Married [ ] Divorced [ ] Single [ ] Separated [ ]Remarried
If both parents are not living together, who has custody?

	No	Yes	Comments
Are there any siblings not listed above?			
Does your child go to daycare?			where:
Does your child go to school?			where:
Does anyone in your family smoke (even outside)?			who
Does your family have any pets?			type:
Do you have smoke alarms in your house?			
Does your family routinely use seatbelts/carseats?			

BIRTH HISTORY of your child
Born: on time - late – premature(how early? gestational age_____weeks) **At what hospital?**

Birth weight: lbs ozs	No	Yes	Comments on "Yes"
Did mom have any problems with pregnancy?			type:
Was your baby born by Cesarean section?			why:
Did your baby have any problems after birth?			type:
Did baby stay in the hospital after mom went home?			why:

PAST MEDICAL HISTORY	No	Yes	Comments on "Yes"
Has your child had any surgery?			when : why:
Has your child ever been hospitalized?			when : why:
Does you child have any chronic or serious medical conditions?			type:
Has your child had any serious accidents or injuries?			type:
Does your child have any developmental problems?			type:
Is your child allergic to any medications?			meds: type reaction:
Did your child miss or skip any vaccines?			which ones:
Does your child take any medications on a regular basis?			med & dose:
Any over the counter medications on a regular basis?			med & dose:

Where did you hear about our practice?

____
____

Extra Comments:

____
____
____
____

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Name:_________________________________ DOB: ____________

FAMILY HISTORY Any family members (parents, siblings, grandparents, aunts or uncles only) have these?							
	No	Yes	Relation/Type Problem		No	Yes	Relation/Type
Active Smoker				High Blood-Pressure			
Allergies				High Cholesterol			
Anemia/Blood				HIV/AIDS			
Asthma				Immune Problems			
Birth Defect				Kidney disease			
Bone/Joint probs				Learning Problems			
Cancer				Liver disease			
Deafness				Lung disease			
Diabetes				Mental Illness			
Drug abuse				Rheumatic Fever			
Eye problems				Seizures			
Genetic Defect				Thyroid disease			
Heart Disease				Tuberculosis			

REVIEW OF SYSTEMS Has your child had any problems with or do you have concerns with any of the following:							
	No	Yes	Comments on "Yes"		No	Yes	Comments on "Yes"
Abdominal Pain				Hearing problems			
Allergy				Heart, murmurs			
Anemia				High blood pressure			
Asthma/wheezing				Illicit drug use			
Attention problems				Joint Pain/swelling			
Bedwetting/soiling				Learning problems			
Bladder/kidney probs				Liver problems			
Bleeding problems				Many ear infections			
Broken Bones				Many headaches			
Cancer/Leukemia				Many sore throats			
Cerebral Palsy				Menstrual problems			
Chickenpox				Nasal problems			
Constipation				Pneumonia			
Cystic Fibrosis				Seizures			
Dental problems				Skin problems			
Developmental probs				Sleep problems			
Diabetes				Speeach/Language			
Emotional/Behavioral				Thyroid problems			
Genetic Disorders				Vision or Eyes			

Any Other Concerns/Extra Comments: ____

____

____

Thank you for your time filling out this form. Please sign below stating to the best of your knowledge the above information is correct.

______________________________ ____________
Signature of parent/guardian date

I have reviewed the above information with the parent/guardian.

______________________________ ____________
Provider signature date