Androscoggin Valley Hospital
North Country Home Health & Hospice Agency
Upper Connecticut Valley Hospital
Weeks Medical Center

WMC Pediatric Database

Patient's Name_____ Sex_____ Date of Birth_____

Father's Name_____ Date of Birth_____ Present marital status_____

Place of Employment_____ Occupation_____

Home Phone #_____ Cell Phone #_____ Home Address_____

Mother's Name_____ Date of Birth_____ Present marital status_____

Place of Employment_____ Occupation_____

Home Phone #_____ Cell Phone #_____ Home Address_____

What is the child's living situation if not with both biological parents? (please circle)

Adoptive parents Foster family Joint custody Single custody with Mom or Dad (circle)

Address of child:_____

Who else lives in the home with the child:_____

Patient's Sibling Child's Name (first and last) Sex Date of Birth Living at home?

1. _____

2. _____

3. _____

Birth History

Birth weight_____ Full term (circle) Yes No Weeks of gestation_____

Were there any issues with the pregnancy or after birth (circle) Yes No If yes, please explain:

_____

General Questions	Yes	No	Details
Do you consider your child to be in good health?			
Does your child see a specialist or any health care professional?			
Has your child had any surgery?			
Has your child ever been hospitalized?			
Is your child allergic to medication or foods?			
Does anyone in the home smoke?			

Patient Medical HIstory

(Please mark any conditions the patient has)	Yes	No	Details
Problems with Ears or Hearing			
Problems with Eyes or Vision			
Asthma or wheezing			
Pneumonia, bronchitis, or bronchiolitis			
Heart problem or murmur			
Anemia			

AFFIX PATIENT LABEL

(Patient Medical History Continued...)	Yes	No	Details
Urinary Tract Infections or kidney problems			
Seizures			
Skin rashes, eczema, acne (circle)			
Depression			
Anxiety			
ADHD or behavioral problems			
Sleep problems or snoring			
Developmental or speech delay			
Bleeding problem - too much or blood clots			
Thyroid disease or growth problems			
Metabolic or genetic diseases			
Other health problems (list details below)			
List Patient Medications and Dosage:			

Additional details _____

Patient surgical history

Please circle any surgeries the patient has had: tonsils adenoids ear tubes appendix
hernia oral/teeth fracture/reduction circumcision
other : _____

Family History

(Please mark affected relatives with an X)	Mother	Father	Sibling	Grandparent	Other relative
Childhood hearing loss					
High blood pressure					
Heart Disease (heart attack, stroke)					
High Cholesterol					
Unexplained sudden death (younger than 35 yrs)					
Asthma					
Bleeding Problem - too much or blood clots					
Substance Abuse - drugs or alcohol (circle)					
Depression					
Anxiety					
Diabetes					
Cancer					
Other health problems (list details below)					

Details _____

Current School _____ IEP or 504 Plan (circle)

AFFIX PATIENT LABEL