HOLYOKE PEDIATRIC ASSOCIATES, LLP	HOLYOKE PEDIATERIC ASSOC, LLP 150 Lower Westfield Road, Holyoke, MA 01040 84 Willimansett Street, South Hadley, MA 01075
Patient Name:	Birth Date:
Do you have any concerns today?	

Allergies to Medications: Yes/No (circle one) Allergies to food/environmental: Yes/No (circle one)

Medication	Reaction	Allergen	Reaction

	Name	Birth date	Medical conditions
Parent			
Parent			
Brother or sister			
Brother or sister			
Brother or sister			
Brother or sister			
Brother or sister			

Any family history of	Yes	No	In whom? Be specific (Mom, Dad, Maternal Grandparent, Paternal Grandparent, Sister, brother, etc)
ADD/ADHD	Y	N	
Autism	Y	N	
Asthma	Y	N	
Hip Dysplasia/Hip dislocation	Y	N	
Deafness	Y	N	
Diabetes	Y	N	
Elevated Cholesterol	Y	N	
Obesity/Overweight	Y	N	
Migraines	Y	N	
Seizures	Y	N	
Strabismus/Lazy Eye	Y	N	
Sudden Death/Heart Attack Before age 55	Y	N	

Parent's Occupation:	Parent's Occupation:	Parents relationship: Single, Married,
		Divorced, Other

List of people that live in patient's home:

Name	Relationship to patient

Does the child live in another home part of the time? If yes list people and relationship to the patient.

Name	Relationship to patient

Child Care (Facility or person who cares for child)

Name:	Days of the week: Su M Tu W Th F Sa

Smokers in the home?	Y	N	Outside only?	Y	N
Fluoride in water?	Y	N	Unknown		
Lead in the home?	Y	N	Unknown removed?		
Wears Bike/Skateboard helmet?	Y	N	Sometimes		
Carseat (rear facing)	Y	N	Carbon monoxide detectors?	Y	N
Carseat (forward facing)	Y	N	Smoke Detectors?	Y	N
Booster Seat?	Y	N	Pets in the home?	Y	N
Seatbelt?	Y	N	Types of pets:		
Guns in the home?	Y	N			
Are they locked up?	Y	N			
Ammunition stored separately?	Y	N			
Guns are kept for?			Occupation Recreation Protection		

Education:

School name:	Grade:	What grades does he/she get in school?

History of chickenpox?	Y	N	Date:

List current medications:

Medication	Dose	How many times a day?	Prescribing Provider

Is the child taking any herbs?

Herb	Dose	How many times a day?	Prescribing Provider

Chronic Illnesses (circle one)	Asthma	Diabetes	Seizures
Others:			

List of Hospitalizations and surgeries:

Date	Hospital	Physician	Reason for hospitalization	Surgical Procedure

Signature of person filling out form	Relationship to patient	Date form filled out

For office use only

Data entered into EMR by	Date entered