Child Health Associates
Boston Children's
Primary Care Alliance

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Please answer the questions on both sides and give these forms to your Nurse when completed.

PLEASE PRINT CLEARLY SO WE CAN ENTER THE CORRECT INFORMATION. THANK YOU

Patient Name: ______________________________ Date of Birth: ____________________

Emergency Contact Name: ______________________ Phone #: ________________________

Relationship to Patient: _________________________

Parent Guardian: ______________________________ Phone #: ________________________

Relationship to Patient: _________________________ DOB: ___________________________

Email: _______________________________________ Occupation: _____________________

Parent Guardian: ______________________________ Phone #: ________________________

Relationship to Patient: _________________________ DOB: ___________________________

Email: _______________________________________ Occupation: _____________________

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single

If not married, with whom does the patient reside: ____

Preferred Method of Contact whenever possible: ☐ Letter ☐ Phone ☐ Email

Patient Medical History	
ADD / ADHD	Yes / No
Allergic rhinitis	Yes / No
Anemia	Yes / No
Asthma	Yes / No
Concussion	Yes / No
COVID-19 Infection	Yes / No
Diabetes mellitus	Yes / No
Eczema	Yes / No
Failure to thrive	Yes / No
GERD	Yes / No
Headache	Yes / No
Hearing Loss	Yes / No
Heart murmur	Yes / No
HIV/AIDS	Yes / No
Inflammatory bowel disease	Yes / No
Jaundice	Yes / No
Lead poisoning	Yes / No
Meningitis	Yes / No
Obesity	Yes / No
Otitis media (recurrent)	Yes / No
Pneumonia	Yes / No
Scoliosis	Yes / No
Seizures	Yes / No
Strep throat (recurrent)	Yes / No
UTI	Yes / No
Varicella	Yes / No
Vision problems	Yes / No
Other medical history:	

Patient Surgical History	
No past surgeries	Yes / No
Circumcision	Yes / No / NA
Gastrostomy	Yes / No
Pyloric stenosis repair	Yes / No
Adenoid removal	Yes / No
Ear tubes	Yes / No
Heart surgery	Yes / No
Tongue tie repair	Yes / No
Appendix removal	Yes / No
Eye alignment repair	Yes / No
Inguinal hernia repair	Yes / No
Tonsil removal	Yes / No
Other surgical history:	

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THANK YOU

Family History (PLEASE PRINT CLEARLY)

If there is a family history of any of the illnesses/diseases listed below, please check the box next to the corresponding family member.

	No Known Problems	Add Problem	Add / ADHD	Alcoholism	Allergic Rhinitis	Anxiety Disorder	Anemia	Asthma	Breast Cancer	Cancer (Childhood Onset)	Colon Cancer	Depression	Developmental Delay	Diabetes	Eczema	Food Allergies	Hearing Loss	Heart Disease (Premature)	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disabilities	Obesity	Seizures	Substance Abuse	Thyroid
Mother																										
Father																										
Sister																										
Brother																										
Mother's Sister																										
Mother's Brother																										
Father's Sister																										
Father's Brother																										
Maternal GM																										
Maternal GF																										
Paternal GM																										
Paternal GF																										
Neg Hx																										