Pediatric Health Associates

Dear_____:

Someone from Pediatric Health Associates recently spoke to you about your child and his or her special health care needs. Along with trying to identify a regular team of doctors/nurse practitioners to serve your child, we would like to update our records and give you a chance to tell us about your child's unique needs. **Please complete this form and return it in the self addressed stamped envelope provided.**

MEDICAL INFORMATION SHEET

(To be completed by parent or primary caregiver)

Date Completed:_____ by:_____

Child's name _____

Parents: (mom)_____ (dad)_____

Address: _____

_____

Phone: Home# (_____) _____ Cell# (___) _____Work#(___)_____

Language spoken at home: _____

Who is the child's primary caregiver? (Usually goes to the doctor, handles health concerns?) _____

_____

If this is someone other than a parent, please list his or her name and phone number: _____

_____

Are there any special parking or arrival (waiting/exam room) needs that it would help us to know about?
(Please explain) _____

_____

_____

What are your child's health concerns? (Please try to list them in order of importance)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.

What medications does your child take on a regular basis?

Does your child have any allergies to medications, foods, or the environment (for example: dust, insects, plants, trees, etc.)? _____

_____

_____

Please list any hospital stays your child has had in the last year and indicate the reason:

Hospitalization Dates	Reason for Admission	Name of Hospital

Does your child receive home nursing care? If yes, please list the agency name, contact person, and phone number:

_____

_____

List any special equipment that your child uses. (For example: wheelchair, special formula, apnea monitor)

_____

_____

_____

What specialists (for example: Allergist, Cardiologist, etc.) does your child see at least once a year?

Doctor's Name	Specialty or Services Provided	Office Phone Number

Does your child receive special services at home, school or through an outside agency (such as physical therapy, speech therapy, or occupational therapy)? Please list them.

_____

_____

Does your child have an Individual Educational Plan (IEP) or 504 Plan at school? Who is the main person at the school to contact for this information? _____

School Name and Phone number: _____

Does your child have any restrictions or special needs at school? (For example: adaptive gym, special diet, can't play outside if it is cold?) _____

_____

_____

_____

What do you see as your greatest need in caring for your child? How do you think we can help?

_____

_____

_____

_____

_____

_____

We look forward to working with you to provide the best medical home possible for your child. If you have any questions, please feel free to contact: _____

at this phone number: _____

Thank you for completing this form,

the staff of Pediatric Health Associates