LUTHER FAMILY CARE

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly we need the following information. All information will remain confidential. Please print.

Patient's Legal Name: (Last)_____(First)_____

SSN:_____ Birthdate:_____

Male or Female

Address:_____

City:_____ State:_____ Zip:_____

Phone Number (the number we can reach you for test results, appts, etc):_____

Email Address:_____

Emergency Contact Name: _____ Relationship:_____

Phone Number:_____

Insurance Information:

Guarantor Information: (if guarantor is patient, omit this section)

Name:_____ Address:_____

Phone Number:_____ SSN:_____ DOB:_____

Relationship to Patient:_____

Primary Insurance:_____ ID:_____

Group # _____

Secondary Insurance: _____ ID #_____

Group #_____

By my signature below I affirm that I have been provided with copies of HIPPA, Patient Bill of Right and I consent to treatment at The Luther Clinic

_____

Patient's Signature (or legal guardian) Date

General

Do you consider your child to be in good health? Yes No Explain_____

Does your child have any special healthcare needs? Yes No Explain_____

Has your child ever been hospitalized? Yes No Explain_____

Is your child allergic to medicine or drugs? Yes No Explain_____

Social History

Please list all those living in the home:_____

Please list other siblings not living in the home:_____

Does the child live with both biological parents: Yes No

If no what is the child's current living situation? Single parent custody, Joint custody, Adoptive Family, Other family members, Foster Care

Birth History

Birth Weight:_____ Full-term, Preterm____ Weeks, Post-term

Delivery: Vaginal Cesarean Reason:_____

Any complications during birth or after birth? Yes No Explain:_____

Did the baby need to go to the NICU? No Yes Explain:_____

During the pregnancy did the mother:

Take prenatal vitamins?	Yes	No	Unknown
Smoke or use e cigarettes?	Yes	No	Unknown
Drink alcohol?	Yes	No	Unknown
Use marijuana?	Yes	No	Unknown
Use illicit drugs?	Yes	No	Unknown
Take other medications?	Yes	No	Unknown. If yes please list:_____

Blood type: Mother_____ Baby:_____

Mothers Lab results:

Hepatitis B: Positive Negative

HIV: Positive Negative

Group B Streptococcus (GBS): Positive Negative

After birth, did the baby get:

Vitamin K shot?_____ Erythromycin eye ointment?_____ Hepatitis B Shot?_____

How was the baby fed? Breast Bottle Both

Did baby go home with biological mother from hospital after birth? Yes No Explain:_____

DK= Don't Know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart Murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies				
Feeding issues or underweight				
Overweight or obesity				
Urinary Tract Infections				
Bed wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone joint or muscle problems				
Frequent headache or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/ genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone Marrow or organ transplant				
Blood transfusion				
HIV/AIDS				
Chickenpox or shingles				
Developmental delays				

School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				

Other Medical Problems: (Please list)

Surgical History

Has your child every had surgery? No Yes If yes please provide details below

Surgery/Procedure	Date of surgery/ child's age	Where completed	Details

Family History

Have any of child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions?

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed wetting after age 10 years					
Cancer before age 55					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack					

Heart disease before age 55					
High blood pressure					
High cholesterol					
HIV/AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death before age 50					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other Medical problems (please list):

Pharmacy: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over the counter drugs. Please include vitamins etc.

DRUG NAME	STRENGTH	FREQUENCY TAKEN

ADDITIONAL HEALTH FACTS: Please add other information you would like the provider to know.

_____

_____

_____

LEGAL GUARDIAN SIGNATURE **DATE**