milcom® Systems for Improved Healthcare
A Division of Hollister Incorporated

CHILD REGISTRATION AND HISTORY RECORD

To be filled out by parent or guardian

The Society of Teachers of Family Medicine

Registration Data

Child's name _____

Date of birth ____/____/____

Gender ☐ Male ☐ Female

Delivery hospital _____

_____

Home address _____ Street

_____ City State Zip

Home phone number ( ) _____ – _____

Your name _____

Your Social Security Number ____ – ____ – ____

Relationship to child _____

Race/ethnicity _____

Religious preference _____

Last grade completed or degree attained _____

Employed by _____

Work phone number ( ) _____ – _____

Medical Insurance Information

Private or Gov't.	Policy Number	Policy Holder	Type of Coverage: Single	Family	Primary	Secondary
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

I hereby authorize Dr. _____ to furnish information to insurance carriers concerning the child's diagnosis and treatments.

Date ____/____/____

Signature _____

I was referred by _____

Person to receive bills ☐ self (skip this section) or

Name _____

Relationship to child _____

Home address _____ Street

_____ City State Zip

Work phone number ( ) _____ – _____

Home phone number ( ) _____ – _____

Pregnancy and Birth

	Yes	No
1. Were there any problems during the mother's pregnancy?	☐	☐
2. Did the mother use any cigarettes, alcohol, recreational drugs or medications during pregnancy?	☐	☐
3. Did the baby come more than 2 weeks early or 2 weeks late?	☐	☐
4. What was the baby's birth weight? _____		
5. Were there any problems during labor or delivery? Vaginal ☐ C–Section ☐	☐	☐
6. Were there any problems during the nursery stay?	☐	☐

Feeding and Digestion

	Yes	No
1. Has the child had any unusual feeding problems?	☐	☐
2. Have there been any problems with diarrhea or constipation?	☐	☐
3. Is your drinking water fluoridated?	☐	☐
4. Does the child ever eat dirt, plaster, or paint?	☐	☐
5. How many meals does the child eat per day? _____		
6. Does the child take vitamins, fluoride, iron, or other supplements?	☐	☐
7. Was/is this child breast-fed? If discontinued, when? _____	☐	☐

Family History

Illnesses – Check ☑ where the child or members of the child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems.

	Child	Child's Family		Child	Child's Family
Frequent ear infections	☐	☐	Diabetes	☐	☐
Frequent colds/sore throats	☐	☐	Kidney/bladder problems or infections	☐	☐
Croup	☐	☐	Seizures/convulsions	☐	☐
Mumps, measles, chicken pox	☐	☐	Early heart disease (age 50 or less)	☐	☐
Wheezing/asthma	☐	☐	High blood pressure	☐	☐
Pneumonia	☐	☐	High cholesterol	☐	☐
Eye problems	☐	☐	Lung disease/tuberculosis	☐	☐
Dental problems	☐	☐	Sexually transmitted diseases	☐	☐
Hearing problems	☐	☐	Alcohol/drug abuse	☐	☐
Hay fever	☐	☐	Emotional disorders/suicide attempts	☐	☐
Eczema/skin problems	☐	☐	Cancer	☐	☐
Anemia/blood problems	☐	☐	Other illnesses	☐	☐

General Health

	First Name	Year of Birth	Sex	Health Good	Poor	(Explain)
Mother				☐	☐	
Father				☐	☐	
Brothers & Sisters				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Have any of the child's brothers or sisters died? No ☐ Yes ☐ (explain) _____

Development and Behavioral Issues

	Yes	No
1. Did the child sit alone by 7 months?	☐	☐
2. Did the child walk alone by 14 months?	☐	☐
3. Did the child say 3 words by 15 months?	☐	☐
4. Is the child doing well in school?	☐	☐
5. Does the child get along well with other children?	☐	☐

6. Check off any of the following problems which the child has:

- ☐ Nightmares/sleep problems
- ☐ Irritable/bad temper
- ☐ Discipline problems
- ☐ Speech problems
- ☐ Thumb sucking
- ☐ Bed wetting
- ☐ Toilet training problems
- ☐ Breath holding

Health and Safety Issues

	Yes	No
1. Are there any guns in the child's house?	☐	☐
2. Does the child use a toothbrush daily?	☐	☐
3. Does the child use a car seat or seat belt all the time?	☐	☐
4. Are there smoke detectors in the child's home?	☐	☐
5. Is the hot water temperature less than 125°?	☐	☐
6. Do you have rules/limits for television viewing?	☐	☐
7. Are medicines and potential poisons out of reach?	☐	☐
8. Do you have syrup of ipecac?	☐	☐
9. Do you know child resuscitation or choking management?	☐	☐

Day Care/School

1. Child's current school: _____ How long? _____
2. Who (relationship) takes care of the child on a typical day?

	Weekday	Weekend
Morning		
Afternoon		
Evening		
Night		
Other		

Hospitalizations or Serious/Unusual Illnesses

Identify any serious and/or unusual illnesses which your child has experienced and the corresponding date(s).

Date	Serious/Unusual Illness	Hospital / Physician's Name	City, State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

List allergies, including any allergic reactions to drugs.

_____

_____

_____

Immunizations

Record either the date or age at which the child received the following immunizations:

	Immunization Sequence											
	1		2		3		4		5		6	
	Date	Age	Date	Age	Date	Age	Date	Age	Date	Age	Date	Age
DPT/DT/dT/Tet	/		/		/		/		/		/	
OPV	/		/		/		/		/			
MMR	/		/									
H. influ. B Type _____	/		/		/		/					
Pneumovax	/		/									
Tine/PPD (specify) _____	/		/		/		/		/		/	
Other _____	/		/		/		/		/		/	

Parent/Guardian Comments

_____

_____

Physician's Comments