Indian Trail Pediatrics
Carolinas HealthCare System

Minor/Child Registration Form

Pt. Name: _____

Date Completed: _____

BIRTH HISTORY

Hospital _____ Obstetrician _____

Type of delivery _____ Complications _____

Birth Weight _____ Birth Length _____ Discharge Weight _____

Did baby have any problems at or immediately after birth? _____

List Age Cooed or Laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

FAMILY HISTORY

HAS ANY MEMBER OF THE FAMILY OR CLOSE RELATIVE HAD:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Chemical Dependency	☐	☐	Heart Disease	☐	☐	Kidney Disease	☐	☐	Tuberculosis
☐	☐	Asthma or Hay Fever	☐	☐	Convulsion or Epilepsy	☐	☐	Hemophilia - Bleeder	☐	☐	Mental Disorders	☐	☐	Other
☐	☐	Cancer	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Migraine			

HEALTH HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now? _____	☐	☐	Medications _____
Receiving any medication or drugs? _____	☐	☐	_____
Has your child been hospitalized? _____	☐	☐	_____

Date Reason Hospital

_____

_____

Allergies _____

_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Allergies	☐	☐	Cancer	☐	☐	Epilepsy/Seizures	☐	☐	Measles	☐	☐	Thyroid Disease
☐	☐	Asthma	☐	☐	Cerebral Palsy	☐	☐	Fainting	☐	☐	Mononucleosis	☐	☐	Tuberculosis
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Hearing Problems	☐	☐	Mumps	☐	☐	Urinary Disease
☐	☐	Anemia	☐	☐	Constipation	☐	☐	Heart Problems	☐	☐	Pneumonia	☐	☐	Vision Problems
☐	☐	Bed Wetting	☐	☐	Diarrhea	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐	Development
☐	☐	Birth Defects	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Sinus Problems	☐	☐	Other
☐	☐	Bladder Problems	☐	☐	Drug/Alcohol Abuse	☐	☐	Liver Disease	☐	☐	Speech Problems			
☐	☐	Bleeding, Excessive	☐	☐	Ear Infections									

DEVELOPMENTAL & SOCIAL HISTORY

Who lives with this child? Please List: _____

YES	NO		YES	NO	
☐	☐	Are both parents involved in the child's life?	☐	☐	Do you have concerns about the child's development?
☐	☐	Is the child in day care or after school program?			Please List: _____
☐	☐	Does anyone smoke in the home?	☐	☐	Do you have issues about the child's problems in school?
☐	☐	Is there a second language used at home?			Please List: _____
		Please List: _____	☐	☐	Does your child participate in sports, church or community activities?

RELEASE

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

_____ _____

Signature of Parent/Guardian Date