Novant Health Medical Group
Pediatric Personal Data

Patient Name __________________________________ **Date of Birth:** ________________ **Today's Date:** __________

Thank you for allowing us to participate in your child's healthcare. Please take a few moments to complete this form. Your healthcare provider will review this information during your child's visit. Filling out all sections will help us to better serve your and your child's health care needs. Please check all boxes that apply in each section.

Do you have any concerns/difficulties that may interfere with your child's appointments or medical care?
□Cost □Memory □Transportation □Hearing □Seeing □Walking/mobility □Reading/writing
□Communication □Problems with English Preferred language spoken: ________________________
□ Other (please specify) ____

How do you best learn new things? □Observing □Hearing □Doing yourself □Reading Last grade completed: _____

□Y □N **Does your child have difficulties with the following?**
□Hearing □Communicating needs □Learning □Memory □Seeing □Reading/writing
□Frequent falls □Understanding English Preferred language spoken: ___________________

□Y □N **Does your child use any of the following?**
□Hearing aid □Glasses □Contacts □Walker □Wheelchair □Cane □Crutches
□Prosthesis (please specify) ____________________________

□Y □N **Does your child need extra/additional assistance (more than age appropriate) with the following?**
□Walking □Going to the bathroom □Dressing □Bathing □Other (please specify) ______________

□Y □N **Is your child experiencing any pain today? (**If yes, additional information will be requested**)**

□Y □N **Has your child been treated for or is there a family history of mental, emotional, behavioral problems or depression?**

□Y □N **Do you have concerns about your or your child's safety in your current relationship/environment?**

□Y □N **Does your child have any special diet needs?**
□Diabetic diet □Lactose intolerance □Gluten free □Food allergy (please specify) ________________
□ Other(please specify) _____________________

□Y □N **Do you have any special cultural or religious beliefs or practices that you would like your child's healthcare provider to know about?**

Parent/Guardian Signature: ___________________________ Date: _______________ Time: _____________

For Office Use
If limited English proficient or hearing impaired, offer interpreter at no additional cost:
□ Interpreter Accepted ____ □ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

To be reviewed by provider with patient/parent/guardian once a year or when changes occur
Reviewed By ________________ Signature / Date & Time: _________ Reviewed By ________________ Signature / Date & Time: _________
Reviewed By ________________ Signature / Date & Time: _________ Reviewed By ________________ Signature / Date & Time: _________