1527 Vernon Road
LaGrange, GA 30240

LAGRANGE PEDIATRICS

Suzie Schuessler, M.D., FAAP

Tel: (706) 883-6363
Fax: (706) 884-5588

HEALTH CHECK HISTORY FORM

PATIENT NAME:_____ PATIENT NO: _____ AGE: _____ DATE:_____

MEDICAID ☐ PEACHCARE ☐ INFORMATION OBTAINED FROM ☐ PATIENT ☐ GUARDIAN ☐ BOTH

GENERAL INFORMATION

☐ Female ☐ Male DOB:_____

Allergies

_____

_____

_____

Current Medications

Name	Dosage	Last Taken
1		
2		
3		
4		

Current Medical History

_____

_____

_____

_____

_____

Maternal / Birth History

☐ Full Term ☐ Premature _____ Wks

Birth Weight _____

Delivery: ☐ Vaginal ☐ C-Section

Duration of Labor _____

Problems with Pregnancy: ☐ Rubella ☐ Toxemia

☐ UTI ☐ Excessive Weight Gain

☐ Alcohol / Drugs ☐ Other _____

☐ Infections ☐ Fever

NEWBORN HISTORY (CIRCLE ALL THAT APPLY)

Feeding Problems	Slow Weight Gain	Breathing Problems	Heart Murmur
Colic	Jaundice	Infection	IV
Blood in Stool	Recurrent vomiting / diarrhea	Low Sugar	Low Blood Count / Anemia
Problem After Birth	Tube, Mask or Bag to Breathe	Other	

VALUES

Religion:_____ Culture: _____

PAST HISTORY

Does your child have, or has he/she ever had:

Asthma, bronchitis, etc.	☐YES ☐ NO	Explain:	_____
Bed Wetting	☐YES ☐ NO	Explain:	_____
Behavior Problems	☐YES ☐ NO	Explain:	_____
Blackout Spells	☐YES ☐ NO	Explain:	_____
Bleeding Problem	☐YES ☐ NO	Explain:	_____
Blood Transfusion	☐YES ☐ NO	Explain:	_____
Broken Bones	☐YES ☐ NO	Explain:	_____
Chicken Pox	☐YES ☐ NO	When?	_____
Constipation	☐YES ☐ NO	Explain:	_____
Diabetes	☐YES ☐ NO	Explain:	_____
Diarrhea	☐YES ☐ NO	Explain:	_____
Eating Problems	☐YES ☐ NO	Explain:	_____
Excess Weight Gain	☐YES ☐ NO	Explain:	_____
Excess Weight Loss	☐YES ☐ NO	Explain:	_____
Eye Problems	☐YES ☐ NO	Explain:	_____
Frequent Ear Infection	☐YES ☐ NO	Explain:	_____
Frequent Vomiting	☐YES ☐ NO	Explain:	_____
German Measles	☐YES ☐ NO	When?	_____
Hay Fever	☐YES ☐ NO	Explain:	_____
Headaches	☐YES ☐ NO	Explain:	_____
Hearing Problems	☐YES ☐ NO	Explain:	_____
Heart Problem	☐YES ☐ NO	Explain:	_____
Immune Problems	☐YES ☐ NO	Explain:	_____
Injuries	☐YES ☐ NO	Explain:	_____
Joint Problems	☐YES ☐ NO	Explain:	_____
Kidney Infections	☐YES ☐ NO	Explain:	_____
Measles	☐YES ☐ NO	When?	_____

1527 Vernon Road
LaGrange, GA 30240

LAGRANGE PEDIATRICS

Suzie Schuessler, M.D., FAAP

Tel: (70c) 883-6363
Fax: (706) 884-5588

HEALTH CHECK HISTORY FORM

PAST HISTORY – CONTINUED

Meningitis	☐YES ☐ NO	Explain:	
Mumps	☐YES ☐ NO	When?	
Nasal Allergies	☐YES ☐ NO	Explain:	
Neurologic Problems	☐YES ☐ NO	Explain:	
Persistent Cough	☐YES ☐ NO	Explain:	
Poisoning	☐YES ☐ NO	Explain:	
Problems Urinating	☐YES ☐ NO	Explain:	
Scarlet Fever	☐YES ☐ NO	Explain:	
Seizures	☐YES ☐ NO	Explain:	
Sinusitis	☐YES ☐ NO	Explain:	
Skin Problems	☐YES ☐ NO	Explain:	
Sleep Problems	☐YES ☐ NO	Explain:	
Soiling Pants	☐YES ☐ NO	Explain:	
Staring Spells	☐YES ☐ NO	Explain:	
Stomach Pain	☐YES ☐ NO	Explain:	
Strep Throat	☐YES ☐ NO	Explain:	
Thyroid Problems	☐YES ☐ NO	Explain:	
Tonsillitis	☐YES ☐ NO	Explain:	
Use of Alcohol/Drugs	☐YES ☐ NO	Explain:	
Vision Problems	☐YES ☐ NO	Explain:	
Whooping Cough	☐YES ☐ NO	Explain:	
Other	☐YES ☐ NO	Explain:	

HOUSEHOLD

People living in the child's home:

Name	Relationship to child	Birth Date	Health Problems

FAMILY HISTORY

Abnormal Fingers or Toes	☐YES ☐ NO	Who?	
Abnormal Teeth	☐YES ☐ NO	Who?	
Alcohol Abuse	☐YES ☐ NO	Who?	
Allergies	☐YES ☐ NO	What/Who?	
Asthma	☐YES ☐ NO	Who?	
Behavior Problems	☐YES ☐ NO	Who?	
Birth Defects	☐YES ☐ NO	Who?	
Bleeding Disorder	☐YES ☐ NO	Who?	
Blindness	☐YES ☐ NO	Who?	
Bowel Disease	☐YES ☐ NO	Who?	
Cancer	☐YES ☐ NO	Who?	
Cleft Lip or palate	☐YES ☐ NO	Who?	
Crippling Arthritis	☐YES ☐ NO	Who?	
Cystic Fibrosis	☐YES ☐ NO	Who?	
Deafness	☐YES ☐ NO	Who?	
Diabetes	☐YES ☐ NO	Who?	
Down's Syndrome	☐YES ☐ NO	Who?	
Drug Abuse	☐YES ☐ NO	Who?	
Early Death	☐YES ☐ NO	Who?	
Eczema	☐YES ☐ NO	Who?	
Epilepsy	☐YES ☐ NO	Who?	
Excessive Weight Gain	☐YES ☐ NO	Who?	

1527 Vernon Road
LaGrange, GA 30240

LAGRANGE PEDIATRICS

Suzie Schuessler, M.D., FAAP

Tel: (70c) 883-6363
Fax: (706) 884-5588

HEALTH CHECK HISTORY FORM

FAMILY HISTORY—CONTINUED

Eye Problems	☐ YES ☐ NO	Who?	______
Gallbladder Disease	☐ YES ☐ NO	Who?	______
Heart Attack (man < 40 or woman < 50 yrs old)	☐ YES ☐ NO	Who?	______
Height > 6 ft 4 in	☐ YES ☐ NO	Who?	______
Height < 5 ft 0 in	☐ YES ☐ NO	Who?	______
Hepatitis B	☐ YES ☐ NO	Who?	______
High Blood Pressure	☐ YES ☐ NO	Who?	______
High Cholesterol	☐ YES ☐ NO	Who?	______
Hyperactivity	☐ YES ☐ NO	Who?	______
Immune Problems	☐ YES ☐ NO	Who?	______
Joint Disease	☐ YES ☐ NO	Who?	______
Kidney Disease	☐ YES ☐ NO	Who?	______
Learning Problems	☐ YES ☐ NO	Who?	______
Leukemia	☐ YES ☐ NO	Who?	______
Liver Disease	☐ YES ☐ NO	Who?	______
Mental Illness	☐ YES ☐ NO	Who?	______
Mental Retardation	☐ YES ☐ NO	Who?	______
Migraines	☐ YES ☐ NO	Who?	______
Nasal Allergies	☐ YES ☐ NO	Who?	______
Overweight	☐ YES ☐ NO	Who?	______
Reading Problems	☐ YES ☐ NO	Who?	______
Rheumatic Fever	☐ YES ☐ NO	Who?	______
Seizures	☐ YES ☐ NO	Who?	______
Sickle Cell Disease	☐ YES ☐ NO	Who?	______
Skin Problems	☐ YES ☐ NO	Who?	______
Stroke	☐ YES ☐ NO	Who?	______
Thyroid Disease	☐ YES ☐ NO	Who?	______
Tuberculosis	☐ YES ☐ NO	Who?	______
Ulcers	☐ YES ☐ NO	Who?	______
Any other problem(s)	☐ YES ☐ NO	What/Who?	______

SOCIAL HISTORY

Day Care	☐ YES ☐ NO	
School Grade	☐ YES ☐ NO	______
Smoking in Home	☐ YES ☐ NO	

ADDITIONAL COMMENTS

______

______

______

______

History Reviewed By/ Date: ______ Signature: ______

1527 Vernon Road
LaGrange, GA 30240

LAGRANGE PEDIATRICS

Suzie Schuessler, M.D., FAAP

Tel: (706) 883-6363
Fax: (706) 884-5588

www.lagrangepediatrics.net

PEDS RESPONSE FORM

Child's Name: _____ Parent's Name: _____

Child's Date of Birth: _____ Child's Age: _____ Today's Date: _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Check One: No Yes A little Comments:

Do you have any concerns about how your child understands what you say?

Check One: No Yes A little Comments:

Do you have any concerns about how your child uses his/her hands and fingers to do things?

Check One: No Yes A little Comments:

Do you have any concerns about how your child uses his/her arms and legs?

Check One: No Yes A little Comments:

Do you have any concerns about how your child behaves?

Check One: No Yes A little Comments:

Do you have any concerns about how your child gets along with others?

Check One: No Yes A little Comments:

Do you have any concerns about how your child is learning to do things for himself/herself?

Check One: No Yes A little Comments:

Do you have any concerns about how your child is learning preschool or school skills?

Check One: No Yes A little Comments:

Please list any other concerns.

1527 Vernon Road
LaGrange, GA 30240

LAGRANGE PEDIATRICS
Suzie Schuessler, M.D., FAAP
www.lagrangepediatrics.net

Tel: (706) 883-6363
Fax: (706) 884-5588

Child's Name _____ Date:_____

Division of Public Health
Prevention Services Branch
Tuberculosis Program
(404) 657-2634
http://health.state.ga.us/programs/tb

Tuberculosis (TB) Risk Assessment

Circle Yes or No.

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest x-ray? Yes No
2. Has the child been in close contact to a person sick with active TB disease? Yes No
3. Was the child born outside the United States or has the child traveled outside the United States? Yes No
4. Does the child have a household member who was born outside the United States or has traveled outside the United States? Yes No
5. Is the child exposed to a person who Yes No
   - Is currently in jail or who has been in jail in the past 5 years?
   - Has HIV?
   - Is homeless?
   - Lives in a group home?
   - Uses illegal drugs?
   - Is a migrant farm worker?
6. Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system? Yes No
7. Is the child / teen in jail or ever been in jail? Yes No