Grand Primary Care

Courtney Smith PA-C

3550 Fairlanes Ave SW, Suite A
Grandville, MI 49418

P: (616) 333-5913
F: (833) 974-5242
admin@grandprimarycare.com

www.grandprimarycare.com

Pediatric Demographics

Full name _____

Date of birth _____

Parent/guardian mobile phone _____

Consent for reminder calls/texts? YES or NO

Consent to sign up for our patient portal? YES or NO

Address _____

_____

Emergency contact (name, phone number) _____

Ethnicity:
- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Prefer not to answer

Race:
- ◯ White
- ◯ Black/African American
- ◯ Native American
- ◯ Asian
- ◯ Pacific Islander
- ◯ Other
- ◯ Prefer not to answer

Primary spoken language _____

Sexual orientation _____

Gender identity _____

Pronouns _____

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Who else lives with the child at their primary residence:

_____

Please describe the arrangement if the patient spends time living in more than one household:

_____

Allergies (and reactions, for example, rash, hives, trouble breathing, etc.):

_____

_____

Current medical problems:

_____

_____

Past medical problems:

_____

_____

Current medications (including over the counter medications, with dose and frequency):

_____

_____

_____

Please list any surgeries and the year the surgery was performed.

_____

_____

_____

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Family history:

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

Social History:

	Yes	No
Have there been any recent changes to the child's family/social situation?		
Do you have smoke detectors and carbon monoxide detectors at home?		
Are there any smokers in the child's home?		
Are there guns present in the child's home?		
If so, are the guns locked away?		
Does the child routinely wear their seatbelt (or use a carseat for young children)?		
Does the child currently or have they ever ever smoked tobacco?		
Does the child currently or have they ever vaped nicotine?		
Does the child currently or have they ever used chewing tobacco?		
Does the child consume alcohol?		
Does the child use any recreational substances?		
Does the child see the dentist twice a year?		

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Does the family have any questions or concerns about any of the following (please circle):

Nutrition	Exercise	Sleep	Social relationships
Substance use	Mental Health	School performance	

Females only:

Age when you had your first menstrual period: _____

Date of your most recent menstrual period: _____