Pediatric Associates of University of Iowa Stead Family Children's Hospital

Monday – Thursday 7:00 am – 8:00 pm Friday 7:00 am – 5:00 pm Saturday 8:00 am – 12:00 pm Sunday 12:00 pm – 4:00 pm

Medical History and Allergy Information

Patient Last Name _____ Patient First Name _____ M.I. _____

Date of Birth _____ ❑ M ❑F Primary Dr. _____

Family Medical History:

Please list if anyone in the patient's immediate family or their grandparents have any of the following conditions:

	Yes	No	Relation to Pt	Age at Onset
Asthma	❑	❑	_____	_____
Cancer	❑	❑	_____	_____
Type: _____				
Thyroid	❑	❑	_____	_____
Kidney Disease	❑	❑	_____	_____
Anemia	❑	❑	_____	_____
Depression, ADHD, Mental Health Problems				
	❑	❑	_____	_____
Type: _____				
Diabetes	❑	❑	_____	_____
Insulin Dependent	❑	❑	_____	_____
Allergies/Hay Fever	❑	❑	_____	_____
Birth Defects	❑	❑	_____	_____

	Yes	No	Relation to Pt	Age at Onset
Lung Disease	❑	❑	_____	_____
Intestinal Disease	❑	❑	_____	_____
Abnormal Cholesterol	❑	❑	_____	_____
Substance Abuse	❑	❑	_____	_____
Hearing Impaired	❑	❑	_____	_____
Learning Disorder	❑	❑	_____	_____
High Blood Pressure	❑	❑	_____	_____
Skin Disorders	❑	❑	_____	_____
Eating Disorders	❑	❑	_____	_____
Urinary Tract Infections Disorders				
	❑	❑	_____	_____
Other:_____			_____	_____

Anyone Younger than 55 with Heart Disease or Stroke ❑Yes ❑No Relation:_____

Other Pertinent Family Medical History: _____

_____

Current Medications: _____

Patient Allergies:

Allergies to Medicines:

List Medicine and Reaction:

_____

_____

Other Allergies:

_____

_____

Other Medical History:

Has the Patient ever been hospitalized, other than at birth? If so, for what and when? _____

_____

Past Surgeries:_____

Chronic Illnesses: _____

Iowa Department of Public Health
Vaccines for Children Program
Patient Eligibility Screening Record
Public Provider

Initial Screening Date: _____

Child: _____
Last Name First Name MI

Date of Birth: _____

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Primary Health Care Provider's Name: _____

The Vaccines for Children (VFC) program is a federally funded program requiring screening and documentation of eligibility status for all patients from birth through 18 years of age. A record must be kept in the health care provider's office that reflects the status of all children receiving immunizations through the VFC Program. The record may be completed by the parent, guardian or individual of record or by the health care provider and should be used for all subsequent visits. It is necessary to retain this or a similar record for each child receiving vaccine for a minimum of three years.

Indicate the child's eligibility status (check only one box):

(a) Enrolled in Medicaid (copy of MCO member ID card required) ☐
(b) Uninsured-no health insurance coverage ☐
(c) American Indian or Alaskan Native (AI/AN) ☐
(d) Underinsured (has health insurance that DOES NOT pay for vaccinations) ☐
(copy of insurance card or name/policy # required)
(Can only receive VFC vaccine at a Federally Qualified Health Center [FQHC], rural health clinic [RHC], or local public health agency [LPHA])
(e) Not eligible for the VFC Program because they do not meet the above criteria (insured) ☐

Office Use Only

This record should be used to document VFC eligibility for all subsequent vaccinations. Information below should be completed by clinic staff.

Eligibility Changes						
Date	Medicaid	No health insurance	AI/AN	Underinsured	Not eligible for VFC	Staff Initials

Vaccines for Children Program - 1-800-831-6293