PEDIATRIC INTAKE

DATE: ______

Patient Name: ______ DOB: ______ Age: ______

Street Address: ______

City: ______ State: ______ Zip Code: ______ Phone: ______

Gender (m/f): ______ Grade of School: ______

Mother's Name and Occupation: ______

Father's Name and Occupation: ______

Parents are (circle): Married Separated Divorced Living Together Other: ______

Insurance Company: ______ Insurance Holder's name: ______

Relationship: ______ Employer: ______

Insurance ID #: ______ Group #: ______ Copay: ______

Deductible (if applicable): ______ Amount used: ______

Reason for Office Visit: ______

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name and city located in: ______

Last time you had blood work done and with what physician: ______

______

List All Surgeries & Hospitalizations, including date occurred:

1) ______ 4) ______

2) ______ 5) ______

3) ______ 6) ______

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List All medicines (from drugstore or prescription) child is on now:

1) ______________________ 4) ______________________

2) ______________________ 5) ______________________

3) ______________________ 6) ______________________

List all supplements child is taking:

1) ______________________ 4) ______________________

2) ______________________ 5) ______________________

3) ______________________ 6) ______________________

Any known Allergies to food, drugs, environment, and animals: ______________________

____

Previous Medical History

YES (Y) indicates the child gets the problem regularly; NO (N) indicates the child never had the problem; PAST (P) indicates the child had the problem in the past, but not recently. Please circle the correct one for your child.

Ear Infections: Y N P If has had, how many total: ________

Colds: Y N P If has had, how many total: ________

Strep Throat: Y N P If has had, how many total: ________

How many times has the child taken antibiotics? ________

What other medicines has the child taken and how often:

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

Hearing Tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Speech Impediments: Yes No Past

Learning Impediments: Yes No Past

Vaccination History

YES, has had; NO, has not; SOME, did not finish all shots:

MMR: Yes No Some DPT: Yes No Some Hep B: Yes No Some

Hib: Yes No Some Chicken Pox: Yes No Some Polio: Yes No Some

Other: ____________________________

Any reactions to vaccinations? If so, please explain: ____________________________

____

Family History

Allergies: Y N P Obesity: Y N P Cancer: Y N P

Tuberculosis: Y N P Mental Illness: Y N P Cardiovascular Disease: Y N P

Diabetes mellitus: Y N P

Mother's Pregnancy History

Age at conception: __________ Did she have other children already? Yes No

Health During Pregnancy

Smoking: Y N Diabetes: Y N Coffee: Y N

Nausea/Vomiting: Y N Recreational Drugs: Y N Emotional Stress: Y N

Preeclampsia: Y N Length of Labor: ______ Vaginal Birth: Y N

Traumatic Birth: Y N

If the birth was difficult, please explain: ____________________________

____

Health of baby at birth: ____________________________

Health History of Child

Child Breastfed: Y N For how long: ______________ When put on formula: __________________ What Formula was used: ____________________ When was child put on solid food: ____________________

When did child walk: _______________ Talk: ______________ Develop Teeth: __________________

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Jaundice as baby:	Y N		Colic:	Y N
Cradle Cap:	Y N		Anemia:	Y N
Eczema or Psoriasis:	Y N		Asthma:	Y N
Diarrhea:	Y N		Warts:	Y N
Constipation:	Y N		Nightmares:	Y N
Finicky Eating:	Y N		Bed-wetting:	Y N
Poor Teeth:	Y N		Tantrums:	Y N
Chronic Sniffles:	Y N		Disobedient:	Y N
Bad Foot Odor:	Y N		Fears/Phobia:	Y N
Very Sweaty Baby/Child:	Y N		Diaper Rash:	Y N
Hyperactivity:	Y N		Early Puberty:	Y N
Growing Pains:	Y N		Stomach Aches:	Y N

Any Particular household stressors child has witnessed or gone through:

1) ______________________ 2) ______________________

3) ______________________ 4) ______________________

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ______________________

____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? ______________________

____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? ______________________

____

Do you spray pesticides, herbicides or other chemicals around your home? ______________________

____

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Typical Day's Diet

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

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