Pediatric Intake Form

Patient Name: **DOB:**

Sex (m/f): **Grade of School:**

Mother's Name and Occupation:

Father's Name and Occupation:

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

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)

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, medications, environment, 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 medications 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

Patient Name: **DOB:**

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 **How many**: ___________

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:**

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

Patient Name: **DOB:**

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/school 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?

Typical Day's Diet

Breakfast:

Lunch:

Dinner:

Snacks:

Allergies

List all known Allergies (food, environment):

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