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PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name _____ Date of first visit _____
Age _____ Date of Birth _____ Gender: female _____ male _____
Mother's name_____ Father's name _____
Address _____ City _____ State _____
Phone # (home) (_____) _____ Parents work # (_____) _____
How did you hear about the practice? _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept _____
_____
Reason for referral or presenting problems _____
_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Antihistamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines_____		

_____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no. _____
_____ Measles _____ Pneumonia _____ Ear infections, no. _____
_____ Mumps _____ Frequent colds _____ other (please list) _____
_____ Rubella _____ Rheumatic fever

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram	.....	.....	.....
Psychological evaluation	.....	.....	.....
Hearing	.....	.....	.....
Speech/Language	.....	.....	.....

Injuries/Surgeries/Hospitalizations (please list): _____

_____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) _____
Any adverse reactions? Y N What ? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PRENATAL HISTORY

Previous pregnancies, miscarriages, or complications?

Mother's age at child's birth? _____
Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth_____
Length of labor _____ Complications? _____
Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____
Child's sleep patterns (first year) _____
Food intolerances (if any) _____
Feeding: Breast fed? _____ how long? _____
Formula? ___ milk / soy _____
Age began solids _____ Which foods? _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** for past symptoms)

_____ Hives	_____ Burning of urine	_____ Bloody urine
_____ Eczema	_____ Frequent urination	_____ Cries easily
_____ Bleeding gums	_____ Heart murmur	_____ Nervous
_____ Nose bleeds	_____ Vomiting spells	_____ Sleep problems
_____ Acne	_____ Anemia	_____ Night sweats
_____ High fevers	_____ Stomach aches	_____ Sensitive to light
_____ Chronic rash	_____ Jaundice	_____ Body/breath odor
_____ Hearing loss	_____ Easy bruising	_____ Motion/car sickness
_____ Diarrhea	_____ Flat feet	_____ No appetite
_____ Sore throats	_____ Constipation	_____ Nightmares
_____ Headaches	_____ Gas	_____ Canker sores
_____ Frequent colds	_____ Bleeding tendency	_____ Unusual fears
_____ Wheezing	_____ Joint pains	_____ Excessive fatigue
_____ Cough	_____ Dizzy spells	_____ Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____ Dinner:

_____

Snacks: _____

To Drink: _____