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New Pediatric Patient Intake Form

Patient Information

Name_____________________Age___Date of Birth__/__/____Sex: F M

Address____________________City__________State_____Zip_________

Phone: _____________________________Alternate___________________

Mother's Name and Occupation__________________________________

Father's Name and Occupation___________________________________

Regular Pediatrician name and city located in______________________

How did you hear about us_______________________________________

Reason (s) for today's Office Visit:

1.____

2.____

Medical History

When did your child last receive healthcare?_______________________

What was the reason______________________________________

Preventative screenings. When was your childs last:

Blood Work____

Eye exam____

Dental exam____

Allergies:

To Medications____

To Foods____

Environmental____

Please list any past surgeries and/or hospitalizations:

1.________________________________Date_______________________

2.________________________________Date_______________________

Medications your child is taking with dosage:
1.____
2.____
3.____

Supplements your child is taking with brand and dosage:
1.____
2.____
3.____

Previous Medical History

Please circle Yes if you child experiences the problem regularly, No if never and No if they have had it but not recently:

Ear Infections:	Yes	No	Past	Toal__________
Colds:	Yes	No	Past	Toal__________
Strep throat:	Yes	No	Past	Toal__________

How many times has the child taken antibiotics?__________________

Vaccination History: Circle Yes if has had, No if has not and Some if incomplete:

MMR:	Yes	No	Some	Chickenpox:	Yes	No	Some
HepB:	Yes	No	Some	Hib:	Yes	No	Some
DPT:	Yes	No	Some	Polio:	Yes	No	Some

Mother's Pregnancy History

Mother's age at birth_____________Number of Children___________

Did she have any health problems during pregnancy?______________

Was the baby born via vaginal birth or C-section (please circle)?

Health of baby at birth_____________________Weight___________

Was the child breastfed?________________For how long?__________

Was the child put on formula?__________At what age?____________

At what age were they given solid food?________________________

Social History

What grade is your child in?_______________________________________

Does he/she get along with other children?__________________________

Does your child drink soda________________ounces/day______________

Sleep: Circle all that apply:

No problems with sleep | Nightmares

Difficulty falling asleep | Difficulty staying asleep

Waking un-refreshed | Hours per night_________________

Bowel movements: Number per day_______Circle all that apply:

Undigested food   Mucous   Blood   Painful   Urgent

Family History

Please indicate any known health condition and age at death and reason for death if applicable for the childs following relatives:

Mother____

Maternal grandmother____________________________________

Maternal grandfather_____________________________________

Father____

Paternal grandmother_____________________________________

Paternal grandfather______________________________________

Siblings____

Health History of Child

Next to the following symptoms circle **C** for currently experiencing, **P** for past or leave it blank if it has never affected you:

Cradle cap: C P

Diaper rash: C P

Jaundice as a baby: C P

Hyperactivity: C P

Depressed mood: C P

Poor attention: C P

Recurrent UTIs: C P

Asthma: C P

Growing pains: C P

Colic: C P

Anemia: C P

IBS or IBD: C P

Constipation: C P

Diarrhea: C P

Heartburn: C P

Stomach aches: C P

Other____________

Other____________

Any thing else you'd like to tell me about your child or their health?

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