



Pediatric Intake Form

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

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: _____

Insurance Company: _____ Insured'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) _____ |

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, 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:** _____

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? _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____
