Pediatric Intake Form

Name____Date______________

Age _________Date of Birth__________ Place of birth___________ Gender: female _____male _____

Address____

City______________________________________State______________Zip Code_____________

Telephone # (home) _____________________________ S.S.# ______________________________

Mother's name___________________________ Father's name__________________________

S.S.# ___________________________________ S.S.# _________________________________

Occupation ______________________________ Occupation ____________________________

Employer ________________________________ Employer ______________________________

Work phone______________________________ Work phone____________________________

Married______ Separated_______Divorced_______Widowed_______Single_______Partnership______

Next of Kin or other to reach in an emergency____

Relationship ___________________________________Phone_____________________________

Address if different____

Primary Health Care Physician

________________________Phone______________________________

When did you last receive medical or health care? ______________________________

What are your most important health problems? List as many as you can in order of importance.

1) ____

2) ____

3) ____

This is to acknowledge that I have been informed and understand the following:

(i) Any treatment or advice provided in this office will not invalidate advice from other health care providers. The patient may concurrently seek the help of other health care providers.

(ii) I agree to pay any fees for services, labwork and medicinary items incurred at the time of the visit. This office does not provide insurance billing, but will provide ICD-9 diagnostic codes.

I hereby authorize and consent to treatment.

Signature____**Date**_____________

FAMILY HISTORY

Check those applicable	Self	Father	Mother	Brothers	Sisters	Spouse	Children
Health: G = Good, P = Poor							
Allergies							
Alzheimer’s							
Alcoholism							
Anemia							
Asthma, Hayfever, Hives							
Arthritis							
Atherosclerosis							
Bleeding disorder							
Cancer							
Candida							
Chronic Headaches							
Colitis							
Diabetes							
Eczema							
Emphysema							
Glaucoma							
Gout							
Hayfever							
Heart Disease							
Heart Murmur							
High Blood Pressure							
Hypoglycemia							
Kidney Disease							
Liver Disease							
Mental Illness							
Pneumonia							
Weight problems							
Seizures/Epilepsy							
Stroke							
Thyroid Problems							
Tuberculosis							
Ulcers							
Venereal Disease							
Age (if living)							
Age at death (if deceased)							
Cause of Death							

Other ____

____

PERSONAL HISTORY

Current weight ______lbs.   Any recent weight loss Y N   Weight gain Y N   How much _____lbs

Current height____________

For the following sections, please circle "Y" for yes or "N" for no.

Childhood Illnesses

Measles	Y N	Chicken pox	Y N	Rheumatic fever	Y N
Mumps	Y N	Diphtheria	Y N	Whooping cough	Y N
Rubella	Y N	Scarlet fever	Y N	Other _______________	

Immunizations

Diphtheria	Y N	Measles /Mumps /Rubella	Y N
Pertussis	Y N	Polio	Y N
Tetanus shot	Y N	Other ____________________________	

Do you have any contagious diseases at this time? Y N

If yes, what? ____

Hospitalization and Surgery

What hospitalizations, surgeries, or blood transfusions have you had?

____

X-rays and Special Studies

Besides dental care, what X-rays, CAT scans, or other studies you have had and why?:

____

Allergies

Are you hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Any environmental substances? ____

Any previous allergy testing and if so what type? ____

Current Medications

Do you take or use?

Laxatives	Y N	Cortisone	Y N	Topical drugs	Y N
Anti-inflammatories	Y N	Antibiotics	Y N		

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)________________________________ 5)________________________________

2)________________________________ 6)________________________________

3)________________________________ 7)________________________________

4)________________________________ 8)________________________________

Describe food intake for a typical day

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Drink ____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE
Y = a condition you have now   P = a condition you had in the past N = a condition you never had

EYES

Any problems?	Y P N

EARS

Frequent ear infections	Y P N
Earaches?	Y P N
Discharge from ears?	Y P N
Sensitivity to noise?	Y P N
Difficulty hearing	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N
Sinus problems?	Y P N
Stuffiness?	Y P N
Hayfever?	Y P N
Nose Bleeds?	Y P N

MOUTH AND THROAT

Cold sores or blisters?	Y P N
Bleeding gums?	Y P N
Dental cavities?	Y P N
Teeth grinding?	Y P N
Frequent sore throat?	Y P N
Swollen glands?	Y P N
Difficulty swallowing?	Y P N
Hoarseness?	Y P N

GASTROINTESTINAL

Bad breath?	Y P N
Vomiting?	Y P N
Abdominal bloating?	Y P N
Belching or passing gas?	Y P N
How many Bowel Movements /day _______	
Is this a change?	Y P N
Constipation	Y P N
Diarrhea?	Y P N
Color of stools? ______________________	
Food in stools?	Y P N
Blood in stools?	Y P N
Mucus in stools?	Y P N
Rectal Itching?	Y P N
Jaundice (yellow skin)?	Y P N

RESPIRATORY

Cough?	Y P N
Sputum?	Y P N
Spitting up blood?	Y P N
Wheezing?	Y P N
Asthma?	Y P N
Bronchitis?	Y P N
Pneumonia?	Y P N
Difficulty breathing?	Y P N

Anything else_________________________

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE
Y = a condition you have now   P = a condition you had in the past   N = a condition you never had

IMMUNE

Unexplained fever? Y P N
Chronic infections? Y P N
Chronically swollen glands? Y P N
Slow wound healing? Y P N

ENDOCRINE

Fatigue? Y P N
Excessive thirst? Y P N
Thirstlessness? Y P N
Excessive hunger? Y P N
Lack of appetite? Y P N
Heat intolerance? Y P N
Cold intolerance? Y P N

NEUROLOGIC

Loss of balance? Y P N
Clumsiness? Y P N

CARDIOVASCULAR

Fainting? Y P N
Heart disease? Y P N
Murmurs? Y P N

BLOOD/PERIPHERAL VASCULAR

Cold hands/feet? Y P N
Easy bleeding or bruising? Y P N
Difficulty stopping bleeding? Y P N
Date of last blood test _________________

EMOTIONAL

Anxiety or nervousness? Y P N
Insomnia? Y P N
Mood Swings? Y P N
Recent loss of loved one? Y P N

MUSCULOSKELETAL

Muscle weakness? Y P N
Muscle spasms or cramps? Y P N
Muscle tremor?
Joint pain or stiffness? Y P N
Broken bones? Y P N

SKIN

Dry/Cracking? Y P N
Bumps/Lumps? Y P N
Scaling/Eczema/Psoriasis? Y P N
Rashes? Y P N
Hives? Y P N
Itching? Y P N
Bruising? Y P N
Fungus? Y P N
Color Change? Y P N
Scars? Y P N
Warts? Y P N
Moles? Y P N
Nails brittle/ misshapen? Y P N
White spots in nails? Y P N
Bite nails? Y P N

URINARY

Difficulty urinating? Y P N
Increased frequency? Y P N
Unexplained urgency to urinate? Y P N
Inability to hold urine? Y P N
Bed wetting? Y P N
Blood in urine? Y P N
Frequent infections? Y P N

Anything else________________________