PEDIATRIC INTAKE HISTORY

Patient Name:____ **Date of Birth:**____________________

Parent (or Guardian) Information: ( ) Mother ( ) Father ( ) Guardian

Last_____________________________________First___ _____ ____________ __MI___________

Date of Birth:______________________________ Gender: ( ) M ( ) F SSN:_______________________

Street Address:____

City____State_________Zip___________

Home Phone: ( ) ____________________Work Phone: ( ) _________________Cell Phone: ( ) ___________

Email: ____

Current Concern(s)

____
____
____
____
____

Current Medications

____
____
____
____
____
____

Allergies

____
____
____
____
____
____

Current Supplements

____
____
____
____
____

Surgical, Injury and Hospitalization History
Please list all surgeries, injuries and hospitalizations and the dates on which they occured.

____
____
____
____
____

Past Medical History

Asthma
Bronchitis
Cancer
Chicken Pox
Croup
Eczema
Frequent Colds
Frequent Ear Infections
Headaches
Psoriasis
Kidney Disease
Thyroid Issues
Tonsillitis
Other ___________________

Family History

Mom: _____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________
Dad: _____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________
Siblings:
_____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________
_____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________

Illnesses:		**Who? Deceased?**
High Blood Pressure	_____ No _____ Yes	____
Diabetes	_____ No _____ Yes	____
Heart Disease	_____ No _____ Yes	____
Osteoporosis	_____ No _____ Yes	____
Cancer	_____ No _____ Yes	____
Stroke	_____ No _____ Yes	____

Other?____

Immunization (Y or N)

_____MMR
_____DPT
_____Influenza
_____Hep B
_____Polio
_____DT

Individual Immunizations:
_____Mumps
_____Tetanus
_____Measles
_____Rubella
_____other

Sleep (Please check all that apply)

8-10 hours per night
6-8 hours per night
Less than 6 hours per night

Undisturbed sleep
Difficulty falling asleep
Difficulty staying asleep

Wake feeling rested
Wake feeling tired

Review of Systems

1.) Constitutional:

weight changes ________No ________Yes ____
fatigue ________No ________Yes ____

2.) Skin/Breast:

pain or mass in breast ________No ________Yes ____
nipple discharge ________No ________Yes ____
skin lesion ________No ________Yes ____

3.) Eyes:

vision problems ________No ________Yes ____

4.) ENT/Mouth:

hearing problems ________No ________Yes ____
sinus problems ________No ________Yes ____
dental problems ________No ________Yes ____

5.) Cardiovascular:

chest pain/shortness of breath ________No ________Yes ____
swelling in legs ________No ________Yes ____
palpitations of heart ________No ________Yes ____

6.) Respiratory:

wheezing or cough ________No ________Yes ____

7.) Gastrointestional:

nausea or vomiting ________No ________Yes ____
diarrhea or constipation ________No ________Yes ____
blood in stool ________No ________Yes ____

8.) Urinary:

pain with urination ________No ________Yes ____
blood in urine ________No ________Yes ____
incontinence ________No ________Yes ____

9.) Hematological:

frequent bruising ________No ________Yes ____
cuts do not stop bleeding ________No ________Yes ____
enlarged lymph nodes ________No ________Yes ____

10.) Psychiatric:

depression ________No ________Yes ____
anxiety ________No ________Yes ____

Signature of Patient: ____ **Date:** _____/_____/_____

Reviewed by Physician:
Date: _____/_____/_____ **Physician Signature:** ____