LOGAN HEALTH

Pediatric Intake History

Patient Given Name:____DOB:____________________

Patient Preferred Name: ___________________________________

Primary Care Provider (MD, NP, PA.ect…):_____________________________ Pharmacy: __________________________

Who is filling out this form: ________________________________ Relationship to patient: _______________________
What is your child being seen for?

____

____

Pregnancy and Birth History

Child born by C-section: ❑ Yes ❑ No Details ____

Gestational Age (weeks into pregnancy) at birth: _________________ Weight: ______________ Length: ____________

Did child have any issues/troubles initially after birth:____

____

Surgical/Hospitalization History			
Procedure/Surgery/Admission	Age/Date	Diagnosis	Hospital

Social History

Who does the patient live with: ____

Siblings: # of Brothers: _________ # of Sisters: _________ Sexually Active: Y / N

Sexual Orientation: (circle) homosexual heterosexual transgender Current Gender Identity: _____________

Tobacco use: Y / N Drug use: Y / N Marijuana use: Y / N Alcohol use: Y / N

School Grade/Occupation: _______________________

Is the patient adopted: Y / N Is the patient in Foster Care: Y / N if yes who is the legal guardian: ________________

Allergies

Drug or Food	Reaction

Current Medications

Name	Dosage	Schedule	Reason for taking

Past Medical History

Please list any major medical history for the patient:

____

____

____

Family History

❑ No known family health problems

❑ Unknown, patient is adopted/in foster care

Do any of your immediate family members have any of the medical problems listed below? Indicate relationship and type of disorder. (M – mother, P – father, B – brother, S – sister, MGM – maternal grandmother, MGF – maternal grandfather, PGM – paternal grandmother, PGF – paternal grandfather, A – aunt, U – uncle, C – cousin)

❑ Anesthesia Reactions ______________________

❑ Asthma __________________________________

❑ Cancer ___________________________________

❑ Genetic Disorder __________________________

❑ Kidney Problems __________________________

❑ Migraine Headaches _______________________

❑ Neurologic disorders_______________________

❑ Stomach or Bowel Issues ___________________

❑ Seizures/Convulsions ______________________

❑ Other ____________________________________

❑ Autoimmune Disorders ______________________________

❑ Bleeding/Clotting Disorder____________________________

❑ Diabetes ____

❑ Genetic Disorder ___________________________________

❑ Liver Disease ______________________________________

❑ Musculoskeletal Disorders ____________________________

❑ Skin Disorders _____________________________________

❑ Swallowing difficulties _______________________________

❑ Thyroid ____

❑ Other ____

Review of Systems:

Please check all problems you're currently experience. You may circle more than one answer for each category.

GASTROINTESTINAL

❑ nausea and/or vomiting

GENERAL

- ❑ Recent fevers, chills or sweats
- ❑ Significant weight loss or weight gain
- ❑ Change in behavior
- ❑ Tiredness or drowsiness
- ❑ Irritability/crankiness
- ❑ Lack of interest in play
- ❑ Loss of appetite
- ❑ Problems related to sleep
- ❑ Headaches
- ❑ Dizziness

URINARY

- ❑ frequent or excessive urination
- ❑ pain on urination
- ❑ urgency to urinate
- ❑ blood in the urine
- ❑ urinary tract infections
- ❑ loss of or change in bladder control
- ❑ other problems ________________

EYES

- ❑ vision changes
- ❑ decreased vision or blurred vision
- ❑ double vision
- ❑ lazy eye or eyes not working together
- ❑ other problems _________________

EARS, NOSE, THROAT

- ❑ hearing loss
- ❑ ringing in ears or tinnitus
- ❑ ear infections or drainage from ears
- ❑ nasal discharge or congestion
- ❑ difficulty swallowing liquids or solids
- ❑ drooling
- ❑ regurgitation through the nose
- ❑ frequent or worsening gagging
- ❑ change in the quality or pitch of voice
- ❑ other problems _________________

CARDIO-RESPIRATORY

- ❑ breathing problems
- ❑ wheezing
- ❑ cough
- ❑ apnea (breathing stops)
- ❑ chest pain
- ❑ heart murmur

Patient Given Name:____Date:____________________

Patient Preferred Name: ___________________________________ DOB:______________________

Current Bowel Regimen:

Please list current bowel regimen including prescribed and over the counter medications. Include name, dose and frequency of administration.

Current Medications			
Name	Dosage	Route (Oral/Rectal)	Frequency

Bowel History

Daily frequency of bowel movements: ____

Description of bowel movements (Liquid, hard, soft): ______________________________________

How frequently does your child have bowel accidents?: _____________________________________

What time of day does your child soil his/herself?: _______________________________________

Previously administered/prescribed bowel regimens. Please check all of the regimens that your child has tried in the past:

- ❑ Milk of Magnesia__________________________
- ❑ Lactulose ______________________________
- ❑ Enema (Saline or Fleets) __________________
- ❑ Bisacodyl (enema or suppository) ___________
- ❑ Senna (Ex-Lax) __________________________
- ❑ Glycerin (oral or suppositories) _______________________
- ❑ Colace ____
- ❑ Miralax ____
- ❑ Mineral Oil _______________________________________
- ❑ Other ____

I hereby certify that all information provided is true and accurate.

Signature:____Date: ___________ Time ______