

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  **Surgical/Hospitalization History** |  |
| Procedure/Surgery/Admission | Age/Date | Diagnosis | Hospital |
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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Allergies** |
| Drug or Food | Reaction |
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| **Current Medications** |
| Name | Dosage | Schedule | Reason for taking |
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**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 ❑ Autoimmune Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Asthma ❑ Bleeding/Clotting Disorder
* Cancer ❑ Diabetes
* Genetic Disorder ❑ Genetic Disorder
* Kidney Problems ❑ Liver Disease
* Migraine Headaches ❑ Musculoskeletal Disorders
* Neurologic disorders ❑ Skin Disorders
* Stomach or Bowel Issues ❑ Swallowing difficulties
* Seizures/Convulsions ❑ Thyroid
* Other ❑ 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
* tummy pain or discomfort
* reflux
* constipation or diarrhea
* loss of or change in bowel control
* other problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN**

* rashes or sores
* birth marks
* changes in skin or hair texture
* other problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MUSCLES AND BONES**

* pain in neck, back, arms or legs
* joint pain or joint swelling
* muscle spasms or cramps
* excessive tightness or muscles
* spasticity
* uncontrolled movement
* abnormal postures
* tremors or tics
* scoliosis/curvature of spine
* broken bones
* other problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENDOCRINE**

* excessive thirst and urination
* excessive sweating
* excessive hunger
* always too cold or too hot
* signs of premature sexual development
* other problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEMATOLOGICAL**

* frequent or easy bruising
* trouble controlling bleeding from cut
* anemia
* ever had a blood transfusion
* other problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

**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

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

Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_