Pediatric Intake Form

Name_____ Date of birth _____ Age _____ Sex M or F

Grade of School:_____

Address: _____

City:_____ State:_____ Zip:_____

Mother's Name and occupation: _____

Father's Name and occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other

Regular Pediatrician name and city located in:_____

Reason for Office Visit:_____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Has child had any blood work done? If yes, please list what:

_____

Please list any operations or hospitalizations and year occurred:

1.
2.
3.

Please list all medicines (from drugstore or prescription) child is on now:

1.
2.
3.
4.

Please list all supplements child is taking:

1.
2.
3.
4.

Any known Allergies to food, drugs, environment, animals: _____

_____

_____

_____

_____

Cameron Wellness Center

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Patient Name:_____ DOB: _____

Previous medical history

Yes indicates the child gets the problem regularly; **No** indicates the child never had the problem; **P**ast indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections?	Yes	No	Past	If has had, how many total? _____
Colds?	Yes	No	Past	If has had, how many total? _____
Strep throat?	Yes	No	Past	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.

2.

3.

4.

Hearing tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Any speech impediments:	Yes	No	Past
Learning impediments:	Yes	No	Don't know

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
Chickenpox:	Yes	No	Some	Polio:	Yes	No	Some

Other:_____

Any reactions to vaccinations? If so, please explain: _____

_____

Family history

Allergies:	Yes	No	Obesity:	Yes	No
Cancer:	Yes	No	Tuberculosis:	Yes	No
Cardiovascular disease:	Yes	No	Mental Illness:	Yes	No
Diabetes mellitus:	Yes	No			

Patient Name:_____ DOB: _____

Mother's Pregnancy history

Age at conception:_____

Did she have other children already? Yes No

Health During Pregnancy

Smoking:	Yes	No	Diabetes:	Yes	No
Coffee:	Yes	No	Nausea/Vomiting:	Yes	No
Recreational drugs:	Yes	No	Emotional Stress:	Yes	No
Preeclampsia:	Yes	No	Length of Labor:	_____	
Vaginal birth:	Yes	No	Traumatic birth:	Yes	No

If the birth was difficult, please explain:

_____

Health of baby at birth:_____

Child breastfed: Yes No For how long:_____

When put on formula:_____ What formula was used:_____

When was child put on solid food:_____

When did child walk:_____ Talk:_____

When did child develop teeth:_____

Health History of child

Jaundice as baby:	Yes	No	Colic:	Yes	No
Cradle cap:	Yes	No	Anemia:	Yes	No
Eczema or psoriasis:	Yes	No	Asthma:	Yes	No
Diarrhea:	Yes	No	Warts:	Yes	No
Constipation:	Yes	No	Nightmares:	Yes	No
Finicky eating:	Yes	No	Bed-wetting:	Yes	No
Poor teeth:	Yes	No	Tantrums:	Yes	No
Chronic sniffles:	Yes	No	Disobedient:	Yes	No
Bad foot odor:	Yes	No	Fears/Phobia:	Yes	No
Very sweaty baby/child:	Yes	No	Diaper Rash:	Yes	No
Hyperactivity:	Yes	No	Early Puberty:	Yes	No
Growing pains:	Yes	No	Stomach aches:	Yes	No

Patient Name:_____ DOB: _____

Any particular household stressors child has witnessed or gone through:

1._____

2._____

Diet

Foods**:** Please list in each food group, the foods that your child currently eats. Grain would include all breads, pasta and other related foods.

Meat:	Fruit:	Veg:	Grain:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Other: _____	_____	_____	_____

Typical Day's Diet:

Breakfast:_____

Snack:_____

Lunch:_____

Snack:_____

Supper:_____

Snack:_____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area?_____

Has the child ever lived in a house with lead paint?_____

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all?_____

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

_____

Does the child seem particularly sensitive to perfumes or other vapors?_____

Additional Comments can be noted on last page.

Patient Name:_____ DOB: _____

Additional Comments: