New Pediatric Patient Intake:

_____ ____/____/_____
Patient's First and Last Name Date of Birth

CHILD'S MEDICAL HISTORY: Mark the following medical issues or conditions that the child has experienced.

- ☐ Abdominal Pain
- ☐ Acne
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ ADHD
- ☐ Autism/PDD
- ☐ Bleeding or Clotting Problem
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chemotherapy
- ☐ Chicken Pox
- ☐ Chronic Skin Problems
- ☐ Concussion
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Dental Problems
- ☐ Developmental Delay
- ☐ Diabetes Mellitus Type I
- ☐ Diabetes Mellitus Type II
- ☐ Downs Syndrome
- ☐ Eczema
- ☐ Frequent Sinus Infections
- ☐ Gastro esophageal Reflux
- ☐ Growth Problems
- ☐ Headache-chronic/Migraine
- ☐ Hearing Problems
- ☐ Heart murmur
- ☐ Heart problem
- ☐ HIV
- ☐ Hypertension
- ☐ Impetigo
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Reflux/VUR
- ☐ Kidney Stones
- ☐ Lacrimal duct stenosis
- ☐ Metabolic Disorder
- ☐ MRSA
- ☐ OCD
- ☐ Pneumonia
- ☐ Pregnancy
- ☐ RSV
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Snoring
- ☐ STD
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Urinary Tract Infection
- ☐ Vision Problems
- ☐ Wheezing
- ☐ _____
- ☐ _____
- ☐ _____

BIRTH HISTORY

Birth Weight _____ Weeks Gestation _____

Birth Complications: ☐ Yes ☐ No _____

SURGICAL, HOSPITALIZATION AND MEDICAL ILLNESS HISTORY

Surgery, Hospitalization, and/or Medical Illness	Date

MEDICATIONS List all prescription medications, nonprescription medications and vitamins.

Medication/Other	Dose	How Many Times Per Day

ALLERGIES List all allergies to medications, foods and/or other agents.

Medication/Food/Other	Side Effect or Allergic Reaction

FAMILY HISTORY:

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Anxiety/Depression/ Mental Illness							
Asthma							
Auto-immune Disease							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Heart Disease							
Hypertension							
Hypercholesterolemia							
Migraine/ Chronic Headaches							
Seizures							
Other:							

SOCIAL HISTORY:

Are There Smokers in the Home ☐ Yes ☐ No Does Child Regularly Eat Nutritious Meals ☐ Yes ☐ No

Exercise Regularly ☐ Yes ☐ No Does Child Often Seem Overwhelmed/Stressed/Sad ☐ Yes ☐ No

Have there been any recent major changes or stresses in child's life ☐ Yes ☐ No If Yes, Explain _____

_____

List all Siblings:

Name and Preferred Name if applicable	Sex	DOB
example: Elizabeth "Beth" Smith	F	01/01/2000

VACCINATIONS:

Vaccinations ☐ Up To Date ☐Behind ☐Chose to Decline Vaccinations

Any Previous Adverse Reactions to Vaccinations? _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Representative Name (Print) _____ Relationship to Patient _____

Signature _____ Date ____/____/____