

Pediatric Intake - Health History

Child's Name: _____ Gender: M / F
 Date of Birth: _____ Time of Birth: _____
 Your Name: _____
 Relationship to Child: _____

Date of last physical exam: _____
 Does child have a primary care physician/other health care providers? Please list.

Vital Information:

Child's Birth date _____ Boy Girl
 Birthplace: City/State _____
 Home Hospital / Birth Center _____
 Mother's Name _____ Birth date: _____
 Occupation _____ Ht _____ Wt _____
 Father's Name _____ Birth date: _____
 Occupation _____ Ht _____ Wt _____
 Names of living brothers and sisters and Birth dates

Was child adopted? Yes No At what age? _____
 If adopted, country of origin _____
 Religious/Spiritual Preference _____

Pregnancy History

Number of pregnancies before this one: _____
 How long was this pregnancy? _____ weeks
 How many months pregnant when prenatal care was begun?

Were there any of the following illnesses or problems?
 Rubella (measles) Accident / Injury Bleeding
 High blood pressure Swelling Sugar in urine
 Excessive weight gain Other infections

Explain: _____
 Medicines or supplements used during pregnancy:

Smoking while pregnant: None Moderate Heavy
 Alcohol while pregnant: None <1 per week >1 per week

Birth Information

How long was labor? _____ Was labor induced? _____
At delivery (check all that apply):
 Breech (feet or bottom first) Cesarean section VBAC
 Breathed and cried immediately Resuscitated In oxygen
Did baby require:
 special nursery blood transfusion antibiotics lights
Did baby have:
 breathing problems yellow jaundice Other _____
At birth:
 Weight: _____ Length: _____ Apgar score _____
 Discharge weight: _____ Length of hospital stay: _____
Did baby receive:
 Vit K Hep B vaccine newborn screening tests

Describe any problems with birth or first days of life :

Family Background

Ethnic origin/Race: Mother: _____ Father: _____
 Married Living together Separated Divorced Single
 Child lives with:
 Both parents Mother Father Guardian
 Other members of household: _____
 Age of home or apartment: _____ Any pets? _____
 Has any parent, brother, or sister died? _____
 Who? _____
 Cause of death _____ Age _____

Please check the box of your child's blood relatives who have ever had any of the following conditions; circle examples in parentheses or write in name of disease, if known:	Mother	Father	Mother's Family	Father's Family	Siblings
Headaches (migraine, cluster, tension)					
Eye Disease (blindness, tumor, glaucoma)					
Ear Disease (deafness, infections, defects)					
Allergies (eczema, hay fever, sinus, hives)					
Lung Disease (asthma, cystic fibrosis, bronchitis)					
Tuberculosis					
High Blood Pressure					
High Cholesterol					
Heart Attack (age _____)					
Heart Disease					
Anemia (Sickle Cell, Mediterranean, other)					
Bleeding Disorders (hemophilia)					
Stomach or Duodenal Ulcers					
Liver or Gallbladder Disease (hepatitis)					
Intestinal Disease (colitis, polyps)					
Kidney Disease (nephritis, cysts, stones)					
Diabetes					
Thyroid Problems (goiter, nodules, hyper-, hypo-)					
Bone or Joint Disease (arthritis, osteoporosis)					
Muscle Weakness or Dystrophy					
Seizure Disorder (epilepsy)					
Neurologic Disorder					
Learning Disability					
Mental Retardation (Down Syndrome, other)					
Mental Illness (depression, anxiety, other)					
Alcoholism or Drug Abuse					
Birth Defects (cleft lip, other deformity)					
Obesity					
Cancer: Breast, Cervix, Uterine, or Ovarian					
Lung, Thyroid, Pancreas, or Kidney					
Bladder, Prostate, or Testicular					
Colon, Stomach, or Oral Cavity					
Leukemia, Myeloma, or Lymphoma					
Skin, Brain, or Bone					
Other _____					

Infant Nutrition

- Breastmilk Duration ____ weeks / months / years
Avg number of nursing episodes/24 hours, currently _____
 Formula Brand _____ Oz/day _____
Age of first use _____

Problems:

- Vomiting Colic Diarrhea Allergies
 Uses Pacifier Uses Bottle
Solid foods: Age when started _____

Childhood Nutrition:

What has your child eaten over the past day?

Breakfast: _____
Lunch _____
Dinner _____
Snacks _____
Fluids _____

Favorite foods

Protein foods: _____
Fruits: _____
Vegetables: _____
Grains: _____

Sleep and Elimination

Bowel movements: _____
Urination/day or wet diapers/day: _____
Where/with whom/ how does child sleep?
Shared room or bed? Crib? Cosleeper? Bunk bed?
On tummy or back? _____
Typical Bedtime: _____ Wake time: _____
#wakings/night _____
Naps: _____ Sleep problems? _____

Medical history

Please check the diseases that your child has had and give age:

- Measles, Rubella _____ Anemia _____
 Mumps _____ Heart Disease _____
 Chickenpox _____ Allergies / Hay fever _____
 Whooping cough _____ Eczema _____
 Scarlet fever _____ Asthma _____
 Rheumatic fever _____ Pneumonia _____
 Convulsions/Seizures _____ Hepatitis _____
 Strep throat _____ Ear Infection _____
 Other illnesses: _____

Has your child ever been injured? _____ Age _____

Injury: _____

Any fractures? _____ Which bone(s)? _____

Any loss of consciousness or concussion? _____

Any accidental poisoning? _____ Age _____

Substance _____

Has your child ever had surgery? _____ Age _____

Type of operation _____

Has your child ever been hospitalized other than for the above?

Describe: _____

Has your child ever had a blood transfusion? _____ Age _____

Has your child worn:

- Glasses Contact lenses Dental braces Leg braces
 Corrective shoes Orthotics in shoes Other braces

Please list all medications and supplements:

Does your child have allergies to any of the following?

- Drugs _____
 Foods _____
 Environment _____

Please check if your child has had:

- Frequent headache Crossed eyes
 Pinkeye More than two earaches a year
 Trouble hearing Frequent nosebleeds
 Stuffy nose most of time More than 6 colds a year
 Chronic cough Shortness of breath with exercise
 Asthma Dizzy spells
 Allergies Easy bruising
 Heart murmur Constant or frequent fatigue
 Frequent stomachaches Frequent diarrhea or constipation
 Poor appetite Frequent urination or accidents
 Bloody, red, or brown urine Frequent bed-wetting after age 5
 Joint pains or swelling Dizziness or fainting spells
 Inability to get to sleep Excessive thirst
 Frequent nightmares or sleepwalking
 Excessive weight gain Eczema
 Signs of sexual development before age 9

Other concerns: _____

Child Development

At what age did your child:

Sit alone _____ Walk alone _____ Feed self _____

Talk (2-3-word sentences) _____ Dress self _____

Toilet trained: Day _____ Night _____

School-age child:

Current grade _____ Days missed this year _____

School Problems:

- reading, writing behavior special needs

Are there any behavior problems at home? _____

Please describe: _____

Immunizations and Screenings

- Immunizations up to date on standard schedule

- Selective immunizations and/or delayed schedule

Please provide copy of immunization record

Please give approximate dates for the following, if done:				
Test	No	Yes	Date(s)	Result
Lead blood test				
TB skin test				
Vision exam				
Hearing test				
Hemoglobin blood test				
Urine test				
Other:				