PEDIATRIC PATIENT INTAKE
Ages 0-10

Patient Information TODAY'S DATE: ___________________

Legal name: Last _______________ First ____________ MI ______ Preferred Name __________________

Birthdate ______________ Legal sex _______________ Gender ______ Pronouns: _________________

Parent/Guardian name(s): ____

Primary care provider ______________________________________ PCP phone # ___________________

Preferred pharmacy and location: ____

What are your main reasons for coming to the clinic today: *Please note priority.* Establish primary care

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Allergies, medications, & supplements

Allergies	**Allergen**	**Reaction**	**Severity**	**Age**
Epi pen?				
No known allergies				

Medications & Supplements	**Name**	**Dose**	**Frequency**
None			
See attached			

Medical History

Immunization	Date	Immunization	Date
Measles/Mumps/Rubella		DTaP/TDaP	
Varicella/chicken pox		Influenza	
Tetanus (alone)		Smallpox	
Hepatitis A/B (please indicate which received)		Polio/IPV	
Rotavirus		Haemophilus influenzae	
Pneumococcal		Other:	

Please indicate any adverse reactions to vaccines received: ____

Major illnesses:	Date	Diagnostic testing/Hospitalizations	Date
Measles		EEG	
Mumps		Psychological evaluation	
Rubella		Hearing testing	
Chicken pox		Speech/language testing	
Rheumatic fever		Vision exam	
Pneumonia		Other:	
Frequent colds		Other:	
Strep throat		Other:	
Ear infections		Other:	
Tonsillitis		Other:	
Other:		Other:	

Family Health History

Condition	Family member(s)	Condition	Family member(s)
Heart disease		Diabetes	
Birth defects		Hypertension	
Arthritis		Tuberculosis	
Cancer (type)		Allergies	
Asthma		Osteoporosis	
Mental illness		Other:	

Gestational History

Please answer parent questions for the parent who birthed the child.

Parent's age during pregnancy: _____________ Previous pregnancies by parent: _____________________

Parent's health during pregnancy: ⩽ Bleeding ⩽ Nausea ⩽ Hypertension

⩽ Tobacco, alcohol, substance use ⩽ Diabetes ⩽ Thyroid problems ⩽ Other: _________________

Gestation term: ⩽ Full ⩽ Premature: _____________ ⩽ Late: ______________

Birth weight: ________________ Length of labor: _________________ APGAR Score: __________

Complications: ⩽ Birth injuries ⩽ Blue baby ⩽ Jaundice ⩽ Seizures ⩽ Fever ⩽ Rash

⩽ Colic ⩽ Cerebral palsy ⩽ Feeding problems ⩽ Other: ____________________________________

Feeding: ⩽ Breastfed (how long): _____________

⩽ Formula fed (how long): ___________ Type: _____________

Began solids (age): ___________________ First foods: ____

Milestones:

Age sitting: _________ Age crawling: ____________ Age walking: ____________ Age talking: ____________

Social History

Living situation: __________________________ Family members in the home: _______________________

Does the child live in more than one home? ____________________________ Any pets: ⩽ YES ⩽ NO

Is the child in school? If so, grade: ___________ School attended: _________________________

Social activities: ____________________________ How much screen time daily? ____________________

Exposures: ⩽ Tobacco smoke ⩽ Lead ⩽ Fuel burning appliances ⩽ Radon

⩽ Other: _________________

Safety screening: ⩽ Wears sunscreen ⩽ Smoke/carbon monoxide detectors in the home

⩽ Wears helmets

⩽ Car seat/booster chair use in cars ⩽ Guns in the home ⩽ Domestic violence in the home

Typical diet: Please list examples of the foods/drinks your child regularly consumes.

Breakfast**:**

____

Lunch:

____

Dinner:

____

Snacks:

____

Beverages:

____

Sleeping habits:

Please describe sleeping patterns, including naps:

____

Any nightmares or sleepwalking? ______________________ Any bedwetting? _______________

Does your child cosleep? _________________

Review of Systems

Please indicate if current (C) or past (P) problems

______ Jaundice
______ Hives
______ Eczema
______ Rashes
______ Allergic reaction
______ Bad breath
______ Body odor
______ Acne
______ Hair loss
______ Burning urine
______ Bloody urine
______ Other: ____________

______ Easy bruising
______ Vomiting spells
______ High fevers
______ Dizzy spells
______ Sore throat
______ Headache
______ Nose bleeds
______ Constipation
______ Diarrhea
______ Stomach ache
______ Poor appetite
______Other: _______________

______ Joint pain
______ Fatigue
______ Coughing
______ Wheezing
______ Heart murmur
______ Light sensitivity
______ Bedwetting
______ Night sweats
______ Nervousness
______ Unusual fears
______ Cries easily
______ Other: ____________