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PEDIATRIC INFORMATION FORM

(Please Print)

Today's Date:	**E-MAIL**:

CHILD'S INFORMATION

Patient's last name: First: Middle:	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:		Home Phone No.: ( )	
		SSN:	
P.O. box:	City:	State:	ZIP Code:

Referred by (Please check one box):	☐ Dr.	☐ Internet	☐ Hospital
☐ Family ☐ Friend ☐ Close to home/work	☐ Magazine / Newspaper	☐ Other	

CONTACT NUMBERS

Parent / Responsible Party:	Phone no.: ( )

CURRENT HEALTH CARE TEAM

Your Pediatrician:	Phone no.: ( )	
Specialty Doctor :	Type of care:	Phone no.: ( )
Specialty Doctor:	Type of care:	Phone no.: ( )
Specialty Doctor:	Type of care:	Phone no.: ( )

DATE:

Please remember to frequently click "save"

Name *(Last, First, M.I.):*

Pediatric intake form

REASON FOR THIS VISIT?

DURATION OF COMPLAINT / SYMPTOMS? ANY OTHER ASSOCIATED SYMPTOMS?

WHAT HAS BEEN DONE SO FAR:	
TREATMENT	**RESPONSE**

PREGNANCY HISTORY	
Duration of Pregnancy?	Birth Weight?
Any complications during pregnancy?	High Blood Pressure?
Any drugs taken during pregnancy? (include over-the-counter medications):	
Any Alcohol? ☐ Yes ☐ No	If yes, How much?
Any Tobacco? ☐ Yes ☐ No	If yes, How much?
Illness / Infections during pregnancy?	

LABOR & DELIVERY HISTORY	
How long was labor?	How did labor begin?
Breech or unusual presentation?	
Cesarean birth? ☐ Yes ☐ No	If yes, what was the reason?
Pain medication used?	
Pitocin used?	Forceps used?
Delay in respiration or cry?	Apgar score, if known?
Was oxygen administration necessary?	
Type of anesthesia employed for mother?	

NEWBORN HISTORY	
Jaundice?	Cyanosis?
Infection?	Seizures?
Anemia?	Home from Hospital in days
Other Important Conditions:	

Please remember to frequently click "save"

Name *(Last, First, M.I.):*

Pediatric intake form (page 2)

CHILDHOOD ILLNESS:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR Measles, Mumps, Rubella

LIST ANY OTHER MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

LIST YOUR CHILD'S PRESCRIBED DRUGS AND OVER-THE-COUNTER MEDS, SUCH AS VITAMINS AND INHALERS

Name the Drug or Vitamin	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

Please remember to frequently click "save"

Name *(Last, First, M.I.):*

Pediatric intake form (page 3)

Family Medical History

Please check if there is any family history of these conditions.

☐ Headaches (Migraines)	☐ Seizures, Epilepsy	☐ Depression
☐ Attention / Behavioral Disorders	☐ Paralysis	☐ Movement disorders
☐ Cancer*	☐ Hay Fever, Allergy, Eczema	☐ Vision/Eye Problems
☐ Diabetes	☐ Thyroid Disease	☐ Other

Notes from above conditions: (ie. types of cancer)

Development (Write Age beside Development)	
1. Smile	8. Crawled
2. Laughed Out Loud	9. Pulled to stand
3. First Words	10. Walked around furniture
4. First Put Words Together ie. "daddy", "bye-bye"	11. Walked unassisted
	12. Rode bicycle
5. Completed sentences	13. Tied shoelaces
6. Rolled over	14. Toilet trained
7. Sat without support	

School assessment (According to parents)	
Grade level?	Reading level?
Behavior?	Attention?
Motivation?	Achievement?
Relationship with teachers & peers?	
Eyesight?	Hearing?
Motor Coordination?	Speech?

QUESTIONS YOU WANT ANSWERED & ANY ADDITIONAL INFORMATION YOU THINK I SHOULD HAVE

Signature _____ Relationship to Child _____ Date _____