Confidential Patient Information
Pediatrics

Patient Contact Information

Name: _____ _____ _____/____/____
(Last) (First) (Sex) (Date of birth)

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____Cell Phone (mom): (___)_____Cell Phone (dad): (___)_____

Email Address:_____

Mother's name and occupation:_____

Father's name and occupation:_____

Parents are: Married Separated Divorced Living Together Other:

Are there any custody arrangements we need to be aware of? Please state:

_____

_____

Sibling's name (s) and ages: _____

School:_____Grade:_____

Additional Patient Information

How did you first hear of us?
From another Patient The Internet/website The Newspaper Other

Name of person to thank for referring you to us:

Does your child also have a Pediatrician they see? Yes No

Name:_____

Were you referred by another physician: Yes No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number:

Infant Intake Form

Patient Name: _____ **Date of Birth:** _____

List in order of importance why you are bringing your infant in today and concerns you may have:

1) _____
2) _____
3) _____

Has the infant been seen by another health care provider? Provider's name:

_____

Mother's Pregnancy History

Age at conception: ___ **Has she given birth previously**? Yes No

Nausea/Vomiting: Yes No **Gestational diabetes**: Yes No **Preeclampsia**: Yes No

Smoking: Yes No **Recreational Drugs**: Yes No **Emotional Stress**: Yes No

Labor and Delivery History

Delivered at how many weeks of pregnancy? _____ **Length of Labor**: _____

Circle all that apply: Pre-term birth (before 36 weeks) post term birth (after 42 weeks) Induced labor

Membrane rupture (water broke) epidural vacuum extraction forceps extraction meconium

Home Birth Birth Center Birth Hospital Birth Vaginal Birth Cesarean Section VBAC

Birth provider(s):_____

If the birth was difficult, please explain: _____

_____

Health of baby at birth: _____ **APGAR scores: /10 /10**

Birth weight: _____**Birth length**_____ **Metabolic screen (heel prick): Yes No**

Hearing test: Yes No Result:_____ **Vitamin K given: Yes No Injection Oral**

Feeding and Development History

Infant Breastfed: **Yes No For how long**: _____**Formula used? Yes No At what age?**_____

Which Formula was used?_____**Age infant started on solid food?**_____

Age child developed teeth: _____**Age infant rolled over:**_____**Age sat up unaccompanied:**_____

Age infant pulled up to a stand: _____ **Age infant took first steps:** _____

List all medicines and/or supplements your infant is currently taking:

1) _____ 3) _____

2) _____ 4) _____

List All Surgeries, Hospitalizations, major illnesses, and accident including date occurred:

1) _____ 3) _____

2) _____ 4) _____

YES indicates the child gets the problem **regularly; NO** indicates the child **never** had the problem**; PAST** 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 yes, how many total**: _____

Colds: Yes No Past **If yes, how many total**: _____

Strep Throat: Yes No Past **If yes, how many total**: _____

How many times has the child taken antibiotics: _____

Does your child have any allergies to any medications or foods? What happens when he/she has an allergic reaction?

Please circle if your child has had any of the following diseases or immunizations. Indicate below if you choose not to vaccinate or vaccinate on a modified schedule:

Measles Mumps German Measles (Rubella) MMR vaccine Yearly flu vaccine
Chicken Pox Chicken Pox vaccine Diptheria Whooping Cough (Pertussis) DTaP vaccine
Hib vaccine Hepatits B vaccine Polio vaccine pneumonia vaccine (Prevnar) Rotavirus vaccine
Not vaccinated Modified vaccination schedule
Any vaccine related reactions?: _____

If child has older siblings, did they have any vaccine related reactions?_____

Family History

	Father	Father's Parents GF GM	Mother	Mother's Parents GF GM	Siblings
Age (if living):					
Age (if deceased):					
Reason for death:					
Cancer type:					
Heart Disease:					
Stroke:					
Asthma/Allergies:					
Mental Illness:					
Auto-Immune Disease:					
Diabetes Mellitus:					

Any Particular household stressors child has witnessed or gone through:

1) _____ 2) _____

3) _____ 4) _____

Sleep

How many hours does your infant generally sleep per night? **Nap hours during the day?**

How many times does your infant wake up during the night?

Where does the child sleep?: With parents In a crib in parent's room In a crib in another room

Foods:

If your infant eats solid foods, please list typical foods your child consumes:

If your child could eat any foods no matter if it was a healthy choice or not, what food(s) would they choose as their favorites (i.e. cheese, milk, ice cream, mac n cheese, bread & butter etc).

Does your child have food aversions? (Foods they strongly dislike or always avoid?)

Does your family follow a specific diet or food modifications i.e. vegan, vegetarian, gluten-free, dairy-free etc.

Tell me what you know so far about your infant's personality:

Review of Systems:

Does your infant have any of these symptoms currently? Mark Yes (Y) or No (N). If they have had a symptom or concern in the past, mark P (past).

GENERAL

Weight concern? Y N P
Growth concern? Y N P

SKIN

Jaundice: Y N P
Rashes: Y N P
Hives: Y N P

HEAD

Head Injury: Y N P
Cradle cap: Y N P
Sweaty head: Y N P
Head concern? Y N P

EYES

Plugged tear duct: Y N P
Dry/Watery/itchy: Y N P
Eye Disease/injury: Y N P
Styes: Y N P
Discharge: Y N P
Vision concern? Y N P

EARS

Chronic ear infections: Y N P
Discharge: Y N P
Hearing concern? Y N P

NOSE

Seasonal Allergies: Y N P
Chronic sniffles: Y N P
Frequent Colds: Y N P
Congestion: Y N P
Runny nose: Y N P
Nosebleeds: Y N P

MOUTH/THROAT

Sore Throat: Y N P

RESPIRATORY

Cough: Y N P
Wheezing: Y N P
Asthma: Y N P
Bronchitis: Y N P
Pneumonia: Y N P
Respiratory concern? Y N P

CARDIOVASCULAR

Heart Murmurs: Y N P
Rheumatic Fever: Y N P
Cardio concern? Y N P

BLOOD/LYMPH

History of anema: Y N P
Type of anemia:_____
Excessive Bruising: Y N P
Bleeding Disorder: Y N P
Blood Transfusion: Y N P

URINARY

Infections: Y N P

GENITALIA

Female:
Labial adhesion: Y N P
Concern? Y N P
Male:
Circumcised? Y N
Concern? Y N P

GASTROINTESTINAL

Reflux: Y N P
Colic: Y N P
Bowel Movement Frequency:
_____
Recent BM Change: Y N
Diarrhea: Y N P
Constipation: Y N P
Diaper rash: Y N P
Nausea/Vomiting: Y N P
Stomach aches: Y N P
Change in Appetite: Y N P

MUSCULOSKELETAL

Growing pains: Y N P
Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P
Pain: Y N P

NEUROLOGICAL

Fainting: Y N P
Vertigo/Dizziness: Y N P
Paralysis: Y N P
Seizures: Y N P

MENTAL/EMOTIONAL

Tantrums: Y N P
Mood Swings: Y N P
High-strung/tense: Y N P
Anxiety: Y N P
Fears/phobias: Y N P