FAMILY MEDICINE CLINIC AND CAMPUS HEALTH CENTER

PEDIATRIC INTAKE FORM (BIRTH - 15 YEARS)

970-642-8413 | 970-641-9017 (FAX)

Child's Name _____ Date of Birth _____ Chart # (Internal Use) _____

Child's Previous Doctor/Primary Care Provider _____

PREGNANCY AND BIRTH

Birth Weight: lbs ozs Birth Length APGAR Score: 1 min. 5 min.

The child's biological status: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____
Delivery by: ☐ Vaginal birth ☐ Cesarean If cesarean, why? _____
Any related complications: ☐ None ☐ Pregnancy ☐ Labor ☐ Delivery ☐ Nursery

GENERAL

Place of Birth: _____ Are the parents: ☐ Married ☐ Unmarried ☐ Divorced ☐ Separated
Has the child had: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis
Do any of the child's caretakers smoke?: ☐ Yes ☐ No If so, who? _____
TV (Hours per day): _____ Computer/Video Games (hours per day): _____
Any repeated Illness? ☐ Yes _____ ☐ No Any surgery? ☐ Yes _____ ☐ No
Any serious Injury? ☐ Yes _____ ☐ No Been hospitalized? ☐ Yes _____ ☐ No
School or learning problems? _____

PATIENT'S HISTORY Please check if your child has had any of the following:

Allergy: ☐ Medications _____ ☐ Hayfever/itchy eyes
Blood/Lymph: ☐ Unexplained Lumps ☐ Easily bruises or bleeds ☐ Anemia ☐ High blood pressure
Cardiovascular: ☐ Easily tires ☐ Shortness of breath ☐ Fainting ☐ Heart disease or murmur
Constitutional/endocrine: ☐ Fevers/Chills ☐ Excessive Sweating ☐ Weight loss or gain
Eyes: ☐ Disease/Injury ☐ Squinting ☐ Crossing eyes ☐ Gazing
Ear/nose/throat: ☐ Congestion ☐ Difficulty Hearing ☐ Mouth breathing/snoring ☐ Bad breath
☐ Frequent runny nose ☐ Problems with teeth/gums (sores)
Gastrointestinal: ☐ Nausea/diarrhea ☐ Constipation ☐ Blood in bowel movement ☐ Abnormal thirst/appetite
Genitourinary: ☐ Bedwetting ☐ Frequent/painful urination ☐ Discharge: penis or vagina
Muscular/skeletal: ☐ Muscle/joint pain ☐ Spine curvature
Neurological: ☐ Headaches ☐ Weakness ☐ Clumsiness
Psychiatric: ☐ Speech problems ☐ Anxiety/stress ☐ Trouble Sleeping ☐ Depression
☐ Behavior
Respiratory: ☐ Prolonged coughing ☐ Wheezing
Skin: ☐ Burns ☐ Birthmarks ☐ Disease ☐ Rashes ☐ Unusual moles

Is the patient currently taking medications? ☐ Yes: _____ ☐ No

FAMILY HISTORY

Please fill in the following information about family members living in the home:

Name	Relationship	Date of Birth	Gender	Health Comments

Please check any family history of the conditions listed below. In addition to immediate family include: uncles, aunts, and grandparents associated with the condition.

☐ Asthma ☐ Alcoholism/drug abuse ☐ Allergies
☐ Arthritis ☐ Birth defects ☐ Blood problems
☐ Cancer ☐ Diabetes ☐ Genetic
☐ Hypertension ☐ Kidney disease ☐ Heart disease
☐ Migraines ☐ Nerve/muscular ☐ Psychological disorders
☐ Seizures ☐ Thyroid problems

Please indicate relative with condition(s): _____

I have filled this form out **COMPLETELY** and to the best of my ability: **Signature:** _____ **Date:** _____

OFFICE USE ONLY Reviewed by: _____ Date: _____

Updated 2/12/2018