Pediatric Intake - Health History

Child's Name: ________________________ *Gender: M / F*
*Date of Birth*_____________ *Time of Birth:*__________
Your Name: ___________________________________
*Relationship to Child:*___________________________

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 :
____

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

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:				

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