Sunshine
Health Care Center

Pediatric Intake Form

Patient Name: _____ DOB: _____

Sex (M/F): _____ Grade of School: _____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Primary Pediatrician Name and City located in: _____

Last time child had blood work done and with what physician: _____

_____

List All Surgeries and Hospitalizations, Including date occurred:

1)_____ 3)_____

2)_____ 4)_____

List All medicines (from drugstore or prescription) child is taking now:

1)_____ 3)_____

2)_____ 4)_____

List all supplements the child is taking now:

1)_____ 3)_____

2)_____ 4)_____

Any known Allergies or Senstitivities to foods, drugs, environment (pollen, animals, etc.), or chemicals (fragrances, cleaners, etc.):_____

_____

Previous Medical History

YES (Y) indicates the child gets the problem **regularly**; **NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past**, **but not recently**. Please circle the correct one for your child:

Ear infections: Y N P If has had, how many total:_____
Colds: Y N P If has had, how many total:_____
Strep Throat: Y N P If has had, how many total:_____

How many times has your child taken antibiotics? _____
What other medicines has the child taken and how often:

1)_____ 3)_____

2)_____ 4)_____

Hearing Tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Speech Impediments:	Yes	No	Past
Learning Impediments:	Yes	No	Past

Vaccination History

YES, has had; **NO**, has not; **SOME**, did not finish all shots in series:

MMR:	Yes	No	Some	**Chicken Pox**:	Yes	No	Some
Hib:	Yes	No	Some	**Hep B**:	Yes	No	Some
DPT:	Yes	No	Some	**Polio**:	Yes	No	Some
Other:	_____						

Any reactions to vaccinations? If so, please explain: _____

_____

Family History

Allergies:	Y	N	P	Mental illness:	Y	N	P
Tuberculosis:	Y	N	P	Cancer:	Y	N	P
Diabetes Mellitus:	Y	N	P	Cardiovascular Dz:	Y	N	P
Obesity:	Y	N	P				

Mother's Pregnancy History

Age at conception:_____ Did mother have other children already? Yes No

Health During Pregnancy

Smoking: Y N
Nausea/Vomiting: Y N
Preeclampsia: Y N
Traumatic birth: Y N
Diabetes: Y N
Length of Labor: _____
Recreational Drugs: Y N
Coffee: Y N
Emotional stress: Y N
Vaginal birth: Y N

If the birth was difficult, please explain:

_____

_____

Health of baby at birth: _____

Health History of Child

Child breastfed: Y N
For how long?_____
When put on formula?_____

What formula was used?_____
When was child put on solid foods? _____

When did child walk_____
Talk_____
Develop teeth_____

Jaundice as baby:	Y	N	Colic:	Y	N
Cradle Cap:	Y	N	Anemia:	Y	N
Eczema or Psoriasis:	Y	N	Asthma:	Y	N
Diarrhea:	Y	N	Warts:	Y	N
Constipation:	Y	N	Nightmares:	Y	N
Finicky eating:	Y	N	Bed-wetting:	Y	N
Poor teeth:	Y	N	Tantrums:	Y	N
Chronic sniffles:	Y	N	Disobedient:	Y	N
Bad foot odor:	Y	N	Fears/phobias:	Y	N
Very sweaty baby/child:	Y	N	Diaper rash:	Y	N
Hyperactivity:	Y	N	Early puberty:	Y	N
Growing pains:	Y	N	Stomach aches:	Y	N

Any particular household stressors your child has witnessed or gone through:

_____

_____

Toxin Exposures

Has your child ever lived near a refinery, polluted area, or in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

Has your child ever lived in a home that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect their health at all?

_____

Does your child seem particularly sensitive to perfumes, gasoline, or other vapors?

_____

Do you spray pesticides, herbicides, or other chemicals in or around your home?

_____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known allergies (food, drug, environment)

_____

_____

_____