Patient Intake Form

Patient Medical History

Who Is completing this form: Patient Mom Dad Other (circle answer)

Today's Date:	Patient's Name:	Date of Birth:	Age:

Who referred the patient for today's visit: Pediatrician:

Reason for today's visit (patient's problem):

PRENATAL HISTORY:

Birth History: Was patient born by **Vaginal delivery** or **C-Section?** (circle answer)

Pregnancy Complications:

Was baby born: **Full Term** or **Premature?** (circle answer) Birth Weight: Birth Length:

MEDICAL HISTORY:

List all **Medications and Dose (if known):**

List any **Hospitalizations:**

List any **Surgeries:**

List any **Allergies:**

FAMILY HISTORY: Do parents, grandparents, brother(s) or sister(s) have a history of the following diseases?

Any Family history of Congenital Heart Disease? Yes or No If yes, which family member and at what age.

Any Family history of other Heart Disease? Yes or No If yes, which family member and at what age.

Any Family history of Sudden Death? Yes or No If yes, which family member and at what age.

Any Family history of Deafness? Yes or No If yes, which family member and at what age.

SOCIAL HISTORY:

Patient lives with (circle answer): Mom Dad Both Parents Other Arrangements:

Does patient attend school? Yes or No **If yes, what grade is patient in:**

Does patient have any learning disablities or developmental delays? Yes or No If yes, please explain:

Does patient participates in sports? Yes or No If yes, what sport:

Does patient participates in PE at school? Yes or No **If No, please explain:**

Please circle any problem(s) listed below the patient currently has or has had in the past 6 months.

General: Weakness, Fatigue, Fever, Chills, Weight Loss, Weight Gain or None

Eyes: Eye drainage, Double Vision, Trouble seeing, Wears Glasses, or None

ENT: Nasal congestion, Ear Pain, Hearing Issues, Nosebleeds, Gum Bleeding, Teething, Sore Throat, or None

Cardio/Vascular: Fast Heart rate, Chest Pain, Murmur, Irregular Heartbeat, or None

GI: Diarrhea, Constipation, Nausea, Vomiting, Abdominal Pain, Blood in Stool, or None

GU: Frequent Urination, Blood in Urine, Hypospadias, Menstrual Issues, or None

Musculoskeletal: Joint Pain/Swelling, Back Pain, Stiffness, Muscle Pain, Scoliosis, or None

Derm: Rash, Skin Sores, Hair Loss, Nail changes, or None

Neurological: Weakness, Seizures, Numbness, or None

Endocrine/Metabolic: Excessive Thirst, Unexplained Weight Gain, Unexplaned Weight Loss, or None

Chest/Pulmonary: Cough, Frequent Pneumonia, Chest Tightness or None

Please write down any other medical problem you would like the physician to know about.____________________

DATE REVIEWED BY PHYSICIAN WITH PATIENT: ____________

PHYSICIAN SIGNATURE: __________________________