Midwest
Women's & Children's
Specialty Group
an affiliate of MEDNAX

# Intake Form

Patient's name: _____ Date of Birth: _____

**REASON FOR VISIT:**
What is the reason for this visit? _____

**PRIMARY CARE PROVIDER:** _____

**BIRTH HISTORY:**
Were there any complications/problems during the pregnancy with your child? □ Yes □ No
If yes, please explain: _____
Was your child born full term? □ Yes □ No If no, how many weeks premature? _____ Birth weight:_____
Please check all that may apply:
□ Neonatal Respiratory Problems □NICU Stay □ Intubation

**MEDICATION HISTORY:**
Is your child allergic to any medications? □ Yes □ No Allergy to latex? □ Yes □ No
If yes, please list medication and allergic reaction:_____

| Medication | Dosage | Schedule (how often) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Immunizations up to date? □ Yes □ No

**SURGICAL HISTORY:**
Any previous surgeries? □ Yes □ No If yes, please list them below:

| Year | Surgery | Reason |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Any complications from surgery or with anesthesia? □ Yes □ No If yes, please explain: _____
_____

Has your child ever been hospitalized? □ Yes □ No If so, why? _____

**SOCIAL HISTORY:**
Is your child enrolled in daycare/preschool? □ Yes □ No Child's current grade in school (if applicable):___
Which best characterizes your child's current diet: (check all that apply)
□ Breastfeeding □ Bottle feeding □ Regular Diet for Age
Any difficulties feeding? □ Yes □ No If yes, please explain: _____
Is your child exposed to tobacco smoke? □ Yes □ No
Who does your child currently live with? _____
Number of Siblings: _____ Are they healthy? □Yes □No

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## MEDICAL HISTORY:

Does your child have any chronic medical conditions? □ Yes □ No

If yes, please list: _____

Has your child recently experienced any of the following: (Check all that apply)

| | | | |
|---|---|---|---|
| Fever | ☐ | Difficulties urinating | ☐ |
| Unexplained weight loss | ☐ | Joint pain or swelling | ☐ |
| Hearing loss | ☐ | Problems walking | ☐ |
| Vision changes | ☐ | Rashes or skin lesions | ☐ |
| Difficulties breathing | ☐ | Seizures | ☐ |
| Wheezing | ☐ | Swelling of lymph nodes | ☐ |
| Chest pain | ☐ | Easy bruising | ☐ |
| Dizziness | ☐ | Bleeding | ☐ |
| Abdominal pain | ☐ | Psychiatric Disorders | ☐ |
| Constipation | ☐ | Behavioral problems | ☐ |
| Diarrhea | ☐ | Recent infections | ☐ |
| Feeding problems or vomiting | ☐ | Recent cough/cold | ☐ |

Any other ailments: _____

## FAMILY HISTORY:

Does anyone in your family have a history or any of the following? (Check if any apply)

| | | | |
|---|---|---|---|
| Allergies | ☐ | Hearing Problems | ☐ |
| Asthma | ☐ | Diabetes | ☐ |
| Bleeding Tendencies | ☐ | Stroke/TIA | ☐ |
| Blood Clots | ☐ | Heart Disease | ☐ |
| Cancer | ☐ | High Blood Pressure | ☐ |
| Anesthesia problems | ☐ | | |

Signature of Person Completing this Form: _____

Relationship to child: _____

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**Below this line to be completed by Physician:**

**Provider Name & Signature:** _____

**Today's Date:**_____ **Time:**_____