All Around Health

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All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with your doctor.

PEDIATRIC MEDICAL INTAKE

Child's Name:_____ Child's Age:_____
Date of first visit: _____
Date of birth: _____ Sex: M F

Who is filling out this form? (Name and Relationship):
_____
Who does the child primarily live with? _____

Guardian Contact Information

Name and relation to child: _____
Address:_____
_____

Phone number: (Home) _____ (Alternate) _____
Email: _____

Name and relation to child: _____
Address:_____
_____

Phone number: (Home) _____ (Alternate) _____
Email: _____

Please list child's current health care providers with their designation (pediatrician, family physician etc.) and contact information:

Do your child have any known life-threatening allergies?
If yes please list:

Pediatric Health Overview
Comprehensive health care requires a complete picture of health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.

PRIMARY HEALTH CONCERNS

In your opinion what are your child's most important health concerns?
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL HISTORY

How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

Current medications or supplements, include dosage:

Past medications or supplements:

How many times has your child had antibiotics?

Does your child have any allergies (medications, environmental)?

Has your child ever experienced any of the following conditions? Please circle

Allergies- seasonal
Allergies- environmental
Difficulty concentrating
Difficulty sleeping
Bronchitis
Ear infections
Frequent colds
Head lice
Hyperactivity
Impetigo
Measles
Meningitis
Mumps
Pneumonia
Sinusitis
Skin rash
Strep throat
Thrush
Tonsilitis
Urinary tract infections
Headaches
Whooping cough
Diarrhea
Appendicitis
Asthma
Eczema
Cancer
Hay fever
Chicken pox
Chronic bedwetting
Chronic nose bleeds
Chronic bruising
Cold sores
Colic
Conjunctivitis (Pink eye)
Constipation
Convulsions
Cradle cap
Croup
Diabetes
Diaper rash
Seizures
Failure to thrive
Other:_____

Has your child had their vision checked?

Has your child had a hearing check?

Has your child been to the dentist?

VACCINATION HISTORY

Have you chosen to vaccinate your child? YES NO
If yes, are they on a standard schedule or delayed/spaced (circle one)

If on a customized schedule please list what vaccines, how many doses and approximate age of vaccination:

Has your child experienced any adverse reactions from vaccinations?
If yes, please explain:

FAMILY HISTORY

Have any close relatives had any of the following conditions:

[ ] Allergies	[ ] Seizures
[ ] Anemia	[ ] Anemia
[ ] Stroke	[ ] Asthma
[ ] Kidney disease	[ ] Birth defects
[ ] Psoriasis	[ ] Depression
[ ] Bleeding disorder	[ ] Eczema
[ ] Mental illness	[ ] High blood pressure
[ ] Juvinile Arthritis	[ ] Hay fever
[ ] High cholesterol	[ ] Autoimmune disease

[ ] Diabetes Early Onset Late Onset

[ ] Cancer What type: Age of diagnosis:

Do either parents or siblings have any history of chronic illness?

LIFESTYLE

Does anyone in the household smoke?

Does the child exercise regularly? How much and what form of activity?

How many hours of television/computer/videogames does your child watch each day?

PRE-NATAL HEALTH AND BIRTH HISTORY

Was the child adopted?
If so, what is the country of origin?

How old was the mother at the time of the child's birth?

Number of previous pregnancies the mother carried to term?

Any problems with conception?

Did the mother receive medical care during pregnancy?

Did the mother have any health concerns during pregnancy?

Did the mother take any prescription drugs during pregnancy?

Did the mother have significant exposure to cigarettes, alcohol or recreational drugs during pregnancy?

Location of birth (circle one) Home Birth Center Hospital

Vaginal delivery or C-Section

Did the mother receive antibiotics during labor?

Any known complications with birth?

Weight of infant at birth:

Term length of pregnancy (how many weeks):

Any health concerns for the infant at birth?

DIET HISTORY

Breast fed? YES NO How long?

Any concerns with breastfeeding/milk supply?

Formula? YES NO How long?
Type of formula used? (Milk, soy other)

At what age was solid food first introduced?

Does your child have any known food allergies?

Does your child have any dietary restrictions? (Religious, vegetarian, vegan)

Is your child a picky eater? YES NO
Any concerns about diet?

Is there anything else you would like to comment on?