



## Pediatric/Adolescent Health History Intake Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex at birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Child's phone Numbe: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Primary Phone number: \_\_\_\_\_ OK to leave message \_\_\_\_ YES \_\_\_\_ NO  
 Secondary phone number: \_\_\_\_\_ OK to leave message \_\_\_\_ YES \_\_\_\_ NO  
 Email address: \_\_\_\_\_ OK to leave Detailed Message \_\_\_\_ YES \_\_\_\_ NO  
 Emergency Contact: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_  
 Insured Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Prenatal History

- A. Mother's Pregnancy: Normal Complications: \_\_\_\_\_  
 B. Gestation: \_\_\_\_\_ weeks  
 C. Birth Location: Hospital Birthing Center Home Other \_\_\_\_\_  
 D. Were: \_\_\_\_\_  
 E. Delivery: Vaginal C-Section Induced  
 F. Complications \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_\_  
 G. Birth Weight: \_\_\_\_ lbs. \_\_\_\_ oz. Length: \_\_\_\_ inches

### PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Please bring copy of Official record of child's vaccination history for our records**

### IMMUNIZATIONS

Please place an X next to each vaccination that your child has received.

	Hepatitis A		Measles
	Hepatitis B		Mumps
	Diphtheria		Rubella
	Pertussis		Varicella (Chicken Pox)
	Tetanus		Influenza
	Haemophilus Influenza Type B		Rotovirus
	Polio		Human Papilloma Virus (HPV)
	Pneumococcal		



**MEDICATIONS**

Please list all medication + over the counter medications that your child is taking with dosages.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

**SUPPLEMENTS:** Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

**ALLERGIES:** Please include mild to severe or life-threatening allergies and reaction (symptoms)

- 1. Medication: \_\_\_\_\_
- 2. Environmental: \_\_\_\_\_
- 3. Food: \_\_\_\_\_

**PAST MEDICAL HISTORY**

**CHILDHOOD ILLNESSES:** (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age	Ear Infections:	No	Yes/Age
ADD:	No	Yes/Age	Eating Disorders:	No	Yes/Age
ADHD:	No	Yes/Age	Eczema:	No	Yes/Age
Alcohol use:	No	Yes/Age	Headaches:	No	Yes/Age
Allergies:	No	Yes/Age	Head lice:	No	Yes/Age
Asthma:	No	Yes/Age	Mononucleosis:	No	Yes/Age
Bedwetting:	No	Yes/Age	Obesity/Overweight:	No	Yes/Age
Behavior issues:	No	Yes/Age	Pink eye:	No	Yes/Age
Bronchitis:	No	Yes/Age	Pneumonia:	No	Yes/Age
Colic:	No	Yes/Age	Colds:	No	Yes/Age
Constipation:	No	Yes/Age	Sinus Infection:	No	Yes/Age
Cough:	No	Yes/Age	Thrush:	No	Yes/Age
Croup:	No	Yes/Age	Vomiting:	No	Yes/Age
Depression/Anxiety:	No	Yes/Age	Whooping cough:	No	Yes/Age
Diaper Rash:	No	Yes/Age	Other Illness:		Age
Diarrhea	No	Yes/Age	Other Illness:		Age
Drug Abuse	No	Yes/Age			

Please comment on any illnesses indicated above:

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**PAST MEDICAL HISTORY**

**HOSPITALIZATIONS**

Reason for Hospitalization

Date

_____	_____
_____	_____
_____	_____

**SURGERIES**

_____	_____
_____	_____
_____	_____

**LABS AND EXAM HISTORY**

Date of last well child check: \_\_\_\_\_

Date of last blood work: \_\_\_\_\_

Date of last urine test: \_\_\_\_\_

Date of last EKG: \_\_\_\_\_

**SOCIAL HISTORY**

Parent's Marital Status:  Single  Married  Divorced  Separated/Not Divorced  Widowed  
 Domestic Partnership

Are there any family disputes/issues we should be aware of at this time? \_\_\_ Yes \_\_\_ No

Living With:  Both Parents  Mother  Father  StepMother  StepFather  Grandparents  
 Foster Family  Other \_\_\_\_\_

Siblings (Indicate names and year of birth)

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

Mother's Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Guardian's Occupation: \_\_\_\_\_

Daycare Location: \_\_\_\_\_

Days/Hours per week attending daycare: \_\_\_\_\_



**SOCIAL HISTORY**

**NUTRITIONAL HISTORY:**

**Infant/Toddlers:**

Type: Nursing Formula/Specify \_\_\_\_\_ Both

Duration:  <15 min  15-30 min  30-45 min  45-60 min

Frequency:  Every Hour  Every other Hour  Every 3 hours  Every 4 hours  Every 5 hours

Amount of formula per feeding:  <1oz  1-2 oz  2-3 oz  3-4 oz  >4oz

Have you started solids yet? If so what type \_\_\_\_\_

How much juice does your infant/toddler drink in a day \_\_\_\_\_ water \_\_\_\_\_

What type of milk does your child drink \_\_\_\_\_ How much per day \_\_\_\_\_

**School Aged/Adolescents:**

What is a typical breakfast \_\_\_\_\_

What is a typical lunch \_\_\_\_\_

What is a typical dinner \_\_\_\_\_

What are typical snacks \_\_\_\_\_

How many glasses of water do you drink each day \_\_\_\_\_

Do you have any special dietary restrictions \_\_\_\_\_

**TV/Computer:** How much time daily (outside of homework) do you spend watching TV/computer screen?  
\_\_\_\_\_

**EXERCISE:** Do you exercise regularly? \_\_\_ Yes \_\_\_ No What type/activity \_\_\_\_\_

How long \_\_\_\_\_ How Often \_\_\_\_\_

**SLEEP:** How many hours of sleep do you get at night on average? \_\_\_\_\_

Do you have trouble falling asleep? \_\_\_ Yes \_\_\_ No Explain: \_\_\_\_\_

How often do you wake up in the middle of the night and for what reasons \_\_\_\_\_

Do you have trouble waking up? \_\_\_ Yes \_\_\_ No Explain: \_\_\_\_\_

Do you feel rested when you wake up? \_\_\_ Yes \_\_\_ No Explain: \_\_\_\_\_

**ENERGY AND STRESS:**

Adolescents: How would you rate your energy on a scale of 1 – 10 with 10 being the most energy? \_\_\_\_\_

How would you rate your stress on a scale of 1 – 10 with 10 being the most stress? \_\_\_\_\_

How do you cope with stress? \_\_\_\_\_

**Bullying:** Are you bullied? \_\_\_ Yes \_\_\_ No. Do You Bully Others \_\_\_ Yes \_\_\_ No

**TRAVEL HISTORY:** Identify any domestic or foreign travel and indicate year of travel:

Place: \_\_\_\_\_ Year \_\_\_\_\_

Place: \_\_\_\_\_ Year \_\_\_\_\_



**Family History**

Please PLACE a "C" For current or "P" for past in the box next to each condition that applies to your family members. For Grandparent, mark MM for maternal grandmother, MF for maternal grandfather, PM for paternal grandmother, and PF for paternal grandfather. Mark "A" for Alive and "D" for Deceased

	Mother	Father	Sibling	Grandparent	Other
Alcoholism					
Allergies					
Anemia					
Anxiety/ Depression					
Asthma or COPD					
Cancer					
Diabetes					
Drug Addiction					
Eczema					
Epilepsy					
Headaches					
Heart Disease incl. Hypertension or heart attack					
Hepatitis					
Kidney Disease					
Mental Illness					
Stroke					
Thyroid					
Other:					