Keystone
NATURAL FAMILY MEDICINE

PEDIATRIC INTAKE

DATE:

Patient Name: _____DOB: _____Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Gender (m/f): _____ Grade of School: _____

Mother's Name and Occupation:

_____

Father's Name and Occupation:

_____

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

Insurance Company: _____Insurance Holder's name: _____

Relationship: _____ Employer: _____

Insurance ID #: _____ Group #: _____

Reason for Office Visit: _____

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

Regular Pediatrician name and city located in:_____

Last time you had blood work done and with what physician:

_____

List All Surgeries & Hospitalizations, including date occurred:

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6) _____

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

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List all supplements child is taking:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Any known Allergies to food, drugs, environment, and animals:

_____

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 the 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:

MMR: Yes No Some **DPT:** Yes No Some **Hep B:** Yes No Some

Hib: Yes No Some **Chicken Pox:** Yes No Some **Polio:** Yes No Some

Other:

Any reaction to vaccinations? Yes No If Yes, please explain _____

Family History

Allergies: Y N P Obesity: Y N P Cancer: Y N P

Tuberculosis: Y N P Mental Illness: Y N P Cardiovascular Disease: Y N P

Diabetes mellitus: Y N P

Mother's Pregnancy History

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

Health During Pregnancy

Smoking: Y N Diabetes: Y N Coffee: Y N

Nausea/Vomiting: Y N Recreational Drugs: Y N Emotional Stress: Y N

Preeclampsia: Y N Length of Labor: _____ Vaginal Birth: Y N

Traumatic 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 food: _____

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/Phobia:	Y N
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity: Y N Diaper Rash:	Y N	Diaper Rash:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Any Household stressors child has witnessed or gone through:

1) _____ 2) _____

3) _____ 4) _____

Toxin Exposure

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

_____

_____

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

_____

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

_____

Typical Day's Diet

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____