Patient Name: _____

DOB: _____

PATIENT INTAKE FORM

HEIGHT	WEIGHT	TEMP
P	R	BP

Briefly describe why your child is here today: _____

_____

Where is the location of pain or abnormality? _____

_____

If there is pain, please rate how severe the pain is:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(1 is minimal pain, 10 is extreme pain)

How long have you noticed the problem?

☐ Couple of days ☐ Couple of weeks ☐ Couple of months

☐ Less than 6 months ☐ 1+ years

When/under what conditions have you noticed the problem?

_____

_____

Do certain things make the problem better or worse?

_____

_____

Are there limitations in activities associated with the problem?

☐ Yes ☐ No If yes, please briefly describe: _____

_____

Medications your child is currently taking (if none, write N/A):_____

_____

_____

_____

PAST MEDICAL HISTORY

Baby was born at (weeks)? _____

What was the baby's birth weight? _____

Please answer the following questions. If the question does not apply to patient, check N/A:

Any problems at birth? ..... ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Any problems (for the child) during pregnancy? ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Injuries? ..... ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Significant Illnesses? ..... ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Surgery or Anesthesia? ..... ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Hospitalizations? ..... ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Allergies (dietary, environmental, medications)? ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Up to date Immunizations? ..... ☐ Yes ☐ No ☐ N/A

Syndromes/Chromosomal or Other Problems? . ☐ Yes ☐ No ☐ N/A

*If yes, describe:*_____

Eyes	☐ N/A ☐ Glaucoma
Cardiac (heart)	☐ N/A ☐ High Blood Pressure ☐ Congenital Heart Disease
Pulmonary	☐ N/A ☐ Asthma/wheezing ☐ Pneumonia
Gastrointestinal	☐ N/A ☐ Crohn's/UC ☐ GE Reflux
Genitourinary	☐ N/A ☐ UTI's ☐ Other
Neurologic	☐ N/A ☐ Seizures ☐ ADD/Hyperactivity
Endocrine (glands)	☐ N/A ☐ Diabetes ☐ Adrenal Disease
Infections	☐ N/A ☐ Hepatitis ☐ Tuberculosis (TB)

FAMILY HISTORY

Abnormal Reaction to Anesthesia
(either patient or family member)? ..... ☐ Yes ☐ No

If yes, please describe: _____

Bleeding Disorders (either patient or family member)? .... ☐ Yes ☐ No

If yes, please describe: _____

Related Diseases (either patient or family member)? ..... ☐ Yes ☐ No

If yes, please describe: _____

What drugs/medications were taken during pregnancy?_____

_____

_____

Were there any problems (for the mother)
during pregnancy? ..... ☐ Yes ☐ No

HOUSEHOLD

Child Lives: ☐ At Home ☐ In a Foster Home ☐ In a Facility

Child lives with? (check all that apply)

☐ Mother ☐ Father ☐ Guardian/Relative

☐ Other _____

Any Siblings? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

SCHOOL

Does your child attend daycare? ..... ☐ Yes ☐ No

Does your child attend preschool? ..... ☐ Yes ☐ No

Does your child attend school?

☐ No ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th

☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

EXTRACURRICULAR ACTIVITIES

Activities/Interests:_____

_____

Patient Name: _____

DOB: _____

SOCIAL HISTORY

Any recent travel? ..... ☐ Yes ☐ No

If yes, where: _____

Alcohol/Drugs? ..... ☐ Yes ☐ No

Is your child employed? ..... ☐ Yes ☐ No

SMOKING STATUS 13 YEARS AND OLDER

Are you a: ☐ Non-Smoker ☐ Current Smoker ☐ Former Smoker

☐ Current - Every Day ☐ Current - Some Day Smoker

☐ Current Status Unknown ☐ Unknown if ever smoked

CONSTITUTIONAL

Are you currently experiencing any constitutional problems?

☐ Fever ☐ Chills ☐ Weight loss ☐ Fatigue ☐ None

☐ Other _____

EYES

Are you currently experiencing eye problems?

☐ Glasses/contacts ☐ Pain ☐ None

☐ Other _____

ENT

Are you currently experiencing ear, nose, throat (ENT) problems?

☐ Ear infections ☐ Congestion ☐ None

☐ Other _____

SKIN

Are you currently experiencing skin problems?

☐ Rashes ☐ Itching ☐ Redness ☐ None

☐ Other _____

CARDIOVASCULAR

Are you currently experiencing any cardiac (heart) problems?

☐ Turning blue ☐ Irregular heartbeat ☐ Heart murmurs ☐ None

☐ Other _____

RESPIRATORY

Are you currently experiencing pulmonary (breathing) problems?

☐ Wheezing ☐ Coughing ☐ Pneumonia ☐ Croup ☐ Asthma

☐ None ☐ Other _____

GASTROINTESTINAL

Are you currently experiencing gastrointestinal problems?

☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ None

☐ Other _____

NEUROLOGIC

Are you currently experiencing neurologic problems?

☐ Learning problems ☐ Dizziness ☐ None

☐ Other _____

MUSCULOSKELETAL

Are you currently experiencing any muscle or joint pain?

☐ Low back pain ☐ Upper back pain ☐ Joint pain ☐ Leg pain

☐ Chest ☐ None

☐ Other _____

HEMATOLOGY

Are you currently experiencing hematologic/lymphatic (blood) problems?

☐ Blood transfusions ☐ Clotting problems ☐ Swollen glands

☐ Bruising ☐ None

☐ Other _____

PSYCHIATRIC

Are you currently experiencing psychiatric problems?

☐ Depression ☐ Anxiety ☐ None

☐ Other _____

ENDOCRINE

Are you currently experiencing endocrine (gland) problems?

☐ Excessive thirst ☐ Too hot ☐ Too cold ☐ None

☐ Other _____

UROLOGY

If you have an appointment with Dr. Hou, Dr. Hutcheson, Dr. Reinberg, Dr. Vandersteen, Dr. Willihnganz-Lawson, Dr. Wolpert, Kirsten Collins, PNP or Judy Reitmeyer-Hunt, PNP continue the survey. If your provider is not listed, skip to the end.

Have you experienced Bladder/Kidney/Urinary Tract Infections?

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+

Have you experienced fever with these infections? ..... ☐ Yes ☐ No ☐ N/A

Blood in urine? ..... ☐ Yes ☐ No

Are you currently experiencing pain when urinating? ..... ☐ Yes ☐ No

Toilet Trained? ..... ☐ Yes ☐ No

How often does your child urinate duing the day?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8+

When your child needs to urinate, is it sudden? ..... ☐ Yes ☐ No

Leak urine during the day? ..... ☐ Yes ☐ No

If yes, how often? _____

Gets up to urinate at night? ..... ☐ Yes ☐ No

If yes, how often? _____

Wet the bed? ..... ☐ Yes ☐ No

If yes, how often? _____

GASTROINTESTINAL

How often does your child stool? _____

Is stool difficult or painful to pass? ..... ☐ Yes ☐ No

Blood in stool? ..... ☐ Yes ☐ No

DR. SIGNATURE