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PEDIATRIC INTAKE FORM (1-3 YEARS)

Patient Name _____ Age _____ Date of birth _____

Parent/Guardian name: _____

What brings you into the office today? _____

_____

What are your top health concerns, for the above named child, in order of importance? _____

_____

_____

General state of health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical: _____ Date of last dental exam, if applicable: _____

Current mediations (including supplements, vitamins, and herbs): _____

_____

Allergies (drugs, food, chemicals, etc.): _____

_____

Past operations or serious illnesses: _____

_____

MEDICAL HISTORY: (Please check)

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Scarlet fever
☐ Strep throat ☐ Pneumonia ☐ Colic ☐ Croup ☐ Bronchitis
☐ Tonsillitis ☐ Ear infection ☐ Allergies ☐ Asthma ☐ Other _____

IMMUNIZATION HISTORY: ☐ Fully vaccinated ☐ No vaccines

If not fully vaccinated, please check which vaccines they have received:

☐ Diptheria Tetanus Pertussis (Dtap) ☐ Flu shot ☐ MMR ☐ Polio
☐ Hepatitis B ☐ Rotavirus ☐ Varicella ☐ Hepatitis A
☐ Pneumoccocal ☐ H. Flu ☐ None

FAMILY HISTORY: (Please note health issues/diseases of each family member)

Father: _____

Mother: _____

Paternal grandfather: _____

Maternal grandfather: _____

Paternal grandmother: _____

Maternal grandmother: _____

Siblings: _____

FEEDING HISTORY:

Breast fed? ☐ Yes ☐ No How long? _____

Formula fed? ☐ Yes ☐ No How long? _____ What type? _____

Solid foods introduced? ☐ Yes ☐ No What age introduced? _____

Food allergies/sensitivities: _____

Describe child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Number of bottles/breast feeds per day: _____ Number of ounces per bottles: _____

Has child begun potty traing? ☐ Yes ☐ No

SLEEP SCHEDULE:

Goes to bed at: _____ Asleep by: _____ Awakes: _____ Awakes rested: _____

Any problems getting to/ staying asleep? _____

_____