Pediatric New Patient Intake Form

Patient Information:

Last name:_____First name:_____
Middle name:_____DOB:(DD/MM/YYYY)_____
Age:_____ Grade in School:_____
Sex:

- ☐ Male
- ☐ Female

Address:_____

City:_____Province/State:_____Postal/Zip code:_____

Parent/Guardian Name and Occupation:_____

Parent/Guardian Name and Occupation:_____

Parents are:

- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Living Together

Phone numbers:

Parent/Guardian 1

(M)_____(W)_____(H)_____

Parent/Guardian 2

(M)_____(W)_____(H)_____

Medical Information:

Most important concern you would like to address:

_____

Additional concerns?

_____

_____

_____

Name of Previous or Current Pediatrician

_____

Has the child been seen by any other doctor(s) for this complaint?

- ☐ Yes
- ☐ No

List any surgeries or hospitalizations the child has had, including date occurred:

_____

_____

_____

_____

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Has the child had any blood work done? If yes, please list when and what:

_____
_____
_____
_____

Please list all medicines and supplements your child it taking:

_____
_____
_____
_____

Any known Allergies to medications:

☐ No

☐ Yes

If yes, list them:

_____

Any known Allergies to food, drugs, environment, animals and their reaction (e.g. peanuts causes hives):

☐ No

☐ Yes

If yes, list them:

_____

Health History of child:

Jaundice as baby	Y	N
Cradle cap	Y	N
Eczema or psoriasis	Y	N
Diarrhea	Y	N
Constipation	Y	N
Finicky eating	Y	N
Poor teeth	Y	N
Chronic sniffles	Y	N

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Bad foot odor	Y	N
Very sweaty baby/child	Y	N
Hyperactivity	Y	N
Growing pains	Y	N
Colic	Y	N
Anemia	Y	N
Asthma	Y	N
Warts	Y	N
Nightmares	Y	N
Bed-wetting	Y	N
Tantrums	Y	N
Disobedient	Y	N
Fears or phobias	Y	N
Diaper rash	Y	N
Early puberty	Y	N
Stomach aches	Y	N

Any particular household stressors child has witnessed or gone through:

Past Medical History:

Regarding the next section: Please circle (Y) if the child currently has the problem, (N) if they've never had the problem and (P) if they had the problem in the past, also fill in the blanks as appropriate.

Ear infection	Y	N	P	If yes, how many times total?	
Colds	Y	N	P	If yes, how many times total?	
Strep Throat	Y	N	P	If yes, how many times total?	
Antibiotic use	Y	N	P	If yes, how many times total?	

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Please list all other medicines your child has taken in the past and how often

_____

_____

_____

_____

Childhood testing

Hearing test normal	Y	N	Not tested
Vision test normal	Y	N	Not tested
Any speech impediments	Y	N	Past
Learning impediments	Y	N	Don't know

Vaccinations

Did you have the following Disease (D), Been Vaccinated (V), or Neither (N)? Select answer

MMR	D V N	Chicken Pox	D V N
DPT	D V N	HIB	D V N
Hep B	D V N	Tetanus	D V N

Other vaccines:_____

Any reactions to vaccinations? If so, please explain:

_____

Family Medical History:

Allergies	Y	N
Cancer	Y	N
Cardiovascular disease	Y	N
Diabetes mellitus	Y	N
Obesity	Y	N
Tuberculosis	Y	N
Mental illness	Y	N

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Mother's Pregnancy History

Mother's age at conception:_____

Did she have other children already?	Y	N

Mother's Health During Pregnancy

Smoking	Y	N
Coffee intake	Y	N
Recreational drugs	Y	N
Preeclampsia	Y	N
Vaginal birth	Y	N
Tuberculosis	Y	N
Diabetes	Y	N
Nausea/vomiting	Y	N
Emotional stress	Y	N
Traumatic birth	Y	N

Length of labor:_____

Infant History

Child's Birth Weight		
Health of baby at birth:		
Child breastfed	Y	N
If yes, for how long?		
Formula fed	Y	N
If yes, type of formula used:		
When was solid food started?		
Child's first foods:		
When did your child develop teeth?		
When did your child walk?		
When did your child talk?		

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Social History:

Diet recall

Breakfast	
Lunch	
Dinner	
Snacks	

Child's favourite foods:

Toxin Exposure

Did you grow up near a refinery, polluted area, or in a home with leaded paint? If so, what sort of pollution?	Y	N
Are you particularly sensitive to perfumes, gasoline or other vapours?	Y	N
Do you use pesticides, herbicides or other chemicals around your home?	Y	N

Additional Information:
Is there anything else you would like Dr. Coleman to know about your child? Please write in the space below.