Pediatric Intake Form

Our Philosophy of Patient Care

We thank you for taking the time to complete the following medical history. We realize this may seem like a lot of information, especially if your condition does not seem related. However, we believe that it is important to have complete knowledge and understanding of your medical background in order to care for you and treat you properly. Many seemingly unrelated symptoms, points of family history, environmental exposures and many other factors can all contribute to your well-being. A thorough medical history is also required by Medicare and insurance companies, in accordance with government standards. This information will be compiled and entered into our electronic health record and will be available to other providers you may see in this facility. All patient information is kept confidential based on HIPAA Guidelines. It takes time to treat everyone properly and thoroughly. We ask for your patience while you are waiting to be seen. Thank you, ColumbiaDoctors.
CROWN Pediatric Intake Form Section 1

Child’s Name ___________________________________________________ Today’s Date ________________________

Date of Birth ___/____/____ Age ________________ Gender M / F

Patient’s Address __________________________________________________________

Telephone number __________________________ Mobile or alternate number ____________________________

Parent/Guardian Information:

Parent 1 Name: ___________________________ Parent 2 Name: ___________________________

Date of Birth: ___________________________ Date of Birth: ___________________________

Address: __________________________________ Address: __________________________________

Phone Number: ___________________________ Phone Number: ___________________________

Work Number: ___________________________ Work Number: ___________________________

Mobile Number: __________________________ Mobile Number: __________________________

Ok to leave message on voicemail of above provided numbers (may contain personal health information)?

Home: Yes____ No____ Mobile: Yes____ No____

Referring Physician __________________________

Please list your child’s pediatrician’s name, address, and phone #:____________________________________

Preferred Pharmacy __________________________ Pharmacy Phone __________________________

Pharmacy Address __________________________

What is the reason for your child’s visit today? __________________________________________________

If your child’s problem causes pain, where is it painful? ___________________________ How long has it been present? _______________

Description of pain _______________ When does it occur? _______________ Severity _______________

Any other symptoms? ___________________________ What makes it better or worse? _______________

Does your child have any medication allergies? Yes__ No__ If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _________________________________________________________________

Does your child have any other allergies? Please list: _________________________________________________

Is your child allergic to latex? Yes__ No__

Please list ALL of your child’s current medications below (use back of page if you need more room)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>When is it given?</th>
<th>Approximate start date of medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child take any non-prescription medications including vitamins or herbal supplements? Yes__ No__

If yes, list: ___________________________________________________________
CROWN Pediatric Intake Form Section 1

Child’s Name_________________________________________ Date of Birth____________________

**BIRTH HISTORY:**
How many weeks gestation at birth?______Birth weight__________Which pregnancy is this child? ______________________

Did mother have health problems during the pregnancy? Yes____No____ Describe:_______________________________

Born by vaginal delivery or c/section?_______________ If c/section, reason:_______________________________

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc)___________________________________________________________

Is your child adopted? Yes____No____ If Yes, please describe the above to the best of your knowledge.

**MEDICAL HISTORY:** Has your child ever had (been diagnosed or treated for) ANY OF THE FOLLOWING (describe)?:

Anemia: Yes____No____
Asthma/Breathing Problems: Yes____No____
Allergies: Yes____No____
Arthritis: Yes____No____
Behavioral Problems: Yes____No____
Bleeding Tendency: Yes____No____
Bowel Problems: Yes____No____
Cancer/Leukemia: Yes____No____
Chicken Pox/Shingles: Yes____No____
Developmental Disorder: Yes____No____
Diabetes: Yes____No____
Ear/Nose/Throat (ENT) Disorder: Yes____No____
Eczema/Skin Disorder: Yes____No____
Eye Disorder: Yes____No____
Growth Disorder: Yes____No____
Heart Disorder/Defect: Yes____No____
High Blood Pressure: Yes____No____
High Cholesterol: Yes____No____
Immune Deficiency Disorder: Yes____No____
Kidney/Urinary Disorder: Yes____No____
Liver Disease: Yes____No____
Seizure: Yes____No____
Thyroid Disorder: Yes____No____
Any Other? Yes____No____

**SURGICAL HISTORY:** List any surgeries your child has had and the approximate date:

Has your child had a blood transfusion? Yes____No____ If yes, when?_________________________________________________________
CROWN Pediatric Intake Form Section 1

Child’s Name_________________________________________ Date of Birth__________________________

FAMILY HISTORY: Does your child have any family members with a history of major illness or conditions? List below:

| Relationship to Patient | Atopic Dermatitis (Eczema): | Yes__ No__ | | Asthma: | Yes__ No__ | | Seasonal Allergies: | Yes__ No__ | | Psoriasis: | Yes__ No__ | | Skin Cancer: | Yes__ No__ | | Melanoma: | Yes__ No__ | | Dysplastic Nvi: | Yes__ No__ | | Scarring Acne: | Yes__ No__ | | Other: | __________________________________________ |

SOCIAL HISTORY:

Parent’s Name: ___________________ Marital Status: _______ Parent’s Occupation: ___________________

Parent’s Name: ___________________ Marital Status: _______ Parent’s Occupation: ___________________

Legal Guardian, if other than parents: ___________________________________________

Other people living in the home: ___________________________________________

Does your child or anyone living in your home smoke? Yes___ No____

Have you ever had problems with lead paint or contamination in your home? Yes____ No____

Do you have pets in your home? Yes____ No____ If Yes, what types? __________________________

Do you have other children? Yes ____ No____ If Yes, how many? ____ What are their ages? __________________________

For female patients if applicable:

Age at first menses? _______ Last menstrual period? _______ Are your child’s menses regular? _______

REVIEW OF SYSTEMS (For each system, please CIRCLE any/all that apply within PAST MONTH or NONE if applicable):

Constitutional: Fever Chills Feeling Poorly Feeling Tired Recent Weight Gain Recent Weight Loss NONE

Eyes: Eye Pain Red Eyes Itchy Eyes Discharge from Eyes Eyesight Problems Dry Eyes NONE

ENT: Ear Ache Loss of Hearing Nosebleeds Nasal Discharge Sore Throat Hoarseness NONE

Cardiovascular: Chest Pain Palpitations Fast Heart Rate Slow Heart Rate Leg Claudication Leg Swelling NONE

Respiratory: Shortness of Breath Wheezing Cough Trouble Breathing with Exertion Trouble Breathing When Flat NONE

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Heartburn Blood in Stool Abdominal Pain NONE

Genitourinary: Pain with Urination Trouble Urinating Genital Discharge Abnormal Vaginal Bleeding (if applicable) NONE

Musculoskeletal: Joint Pain Joint Stiffness Joint Swelling Limb Pain Limb Swelling NONE

Integumentary: Skin Lesions Skin Wound Itching Change in a Mole Breast Pain Breast Lump NONE

Neurological: Confusion Convulsions Dizziness Fainting Limb Weakness Difficulty Walking NONE

Psychiatric: Suicidal Sleep Disturbance Anxiety Depression Change in Personality Emotional Problems NONE

Endocrine: Muscle Weakness Feelings of Weakness Hot Flashes Deepening of the Voice NONE

Heme/Lymph: Easy Bruising Easy Bleeding Swollen Glands NONE

Other (Please Explain) ___________________________________________

Parent/Guardian Signature_________________________________________ Date________________________

FOR OFFICE USE ONLY:

CROWN-8-12-11 intake

I have reviewed all sections of the intake form and entered relevant information as applicable into CROWN.

Physician Signature_________________________ Date________________________