

Hudson's Bay Medical Group
100 E 33rd St Ste 206
Vancouver WA 98663
PEDIATRIC INTAKE FORM

Doctor's Name: _____ Date: _____

Patient First Name: _____ MI: _____ Patient Last Name: _____

Mother's Name: _____ Father's Name: _____

Date of Birth: _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

1: _____

2: _____

3: _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses:	Rheumatic fever	Y N	German Measles	Y N
	Chicken Pox	Y N	Measles	Y N
	Tonsillitis	Y N	Rubella	Y N
	Ear Infections	Y N	Hepatitis	Y N

Has your child had any of the following tests?: When Where

Electroencephalogram (EEG) _____

Psychological Evaluation _____

Hearing Tests _____

Speech/Language Tests _____

What hospitalizations, surgeries or injuries has your child had?

Immunizations:	Polio	Y N	Pertussis	Y N
	Tetanus Shot	Y N	Diphtheria	Y N
	Measles/Mumps. Rubella	Y N	Influenza	Y N
	Adverse reactions	Y N	If Yes, what?	_____

Safety:

Does your child wear a seat belt?	Y N
Does your child ride in a car seat?	Y N
Does your child wear a bicycle helmet?	Y N
Is your child exposed to second hand smoke?	Y N
Has your child been exposed to lead?	Y N
Does your child wear sunscreen?	Y N
Do you have firearms in the home?	Y N

Allergies:

Is your child hypersensitive or allergic to?

Any drugs? _____

Any foods? _____

Any environments? _____

Breast fed? _____ how long? _____ Formula? _____ milk/soy _____

Typical Food Intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please list any prescription medications, over the counter medications, vitamins, or other supplements your child is taking.

1: _____	4: _____
2: _____	5: _____
3: _____	6: _____

REVIEW OF SYSTEMS

Y=a condition now **P**=a condition in the past **N**=never had

Mental/Emotional

Mood swings	Y P N	Anxiety/Nervousness	Y P N
Irritability	Y P N	Cries Easily	Y P N
Hyperactivity	Y P N	Unusual fears	Y P N
Introvert/Extrovert	Y P N	Sleep Problems	Y P N
Motion/car sickness	Y P N	Nightmares	Y P N

ENDOCRINE

Heat/cold intolerance	Y P N	Fatigue	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N

