NORTH COAST FAMILY HEALTH

875 Greenland Rd., Unit A-1, NH 03801 • 603-427-6800

PEDIATRIC INTAKE FORM

Welcome! It is our goal to provide your child with the best possible health care. In order to serve you optimally, please answer the following questions about your child's health history and lifestyle. Thanks!

PATIENT INFORMATION

Name_____ Birthdate: _____ Age: ____ Sex _____

Address_____ _____ _____ _____
Street City State Zip

Home Phone_____ Cell: _____ Email Address: _____

Mother's Name: _____ Mother's Phone (during the day): _____

Father's Name: _____ Father's Phone (during the day): _____

Other Caretaker: _____ Relationship: _____ Phone _____

Emergency Contact: _____ Relationship: _____ Phone _____

Address: _____

How did you learn about us? _____

Payment Today By: ___ Cash ___ Check ___ Credit Card (Visa, MasterCard, Discover, American Express)

CURRENT HEALTH PROBLEMS

Please list the health problems that are the reason for this appointment:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS

Medications:	Current	Past	Frequency	**Supplements:**	Current	Past	Dose
Aspirin	_____	_____	_____	Vitamins	_____	_____	_____
Tylenol	_____	_____	_____	Minerals	_____	_____	_____
Antibiotics	_____	_____	_____	Fluoride	_____	_____	_____
Decongestants	_____	_____	_____	Herbs	_____	_____	_____
Other _____	_____	_____	_____				
Other _____	_____	_____	_____				
Other _____	_____	_____	_____				

Allergies or adverse reactions to drugs/medications: _____

What happens? _____

_____

CHILDHOOD ILLNESSES

___ Chicken Pox ___ Scarlet Fever ___ Mononucleosis ___ Measles ___ Mumps
___ Rubella ___ Rheumatic Fever ___ Ear Infections ___ Strep Throat ___ Tonsillitis
___ Pneumonia ___ Other _____ ___ Other _____

IMMUNIZATIONS

Type	Date(s)	Adverse Reactions
Measles, Mumps, Rubella (MMR)	_____	_____
DPT	_____	_____
Polio	_____	_____
Varicella (Chicken Pox)	_____	_____
Hepatitis B	_____	_____
Tetanus	_____	_____
Polio	_____	_____
Other	_____	_____

SERIOUS INJURIES, ILLNESSES, ACCIDENTS, AND SURGERIES

Please list incident and date of any hospitalizations, surgeries, accidents, and/or serious injuries and illnesses:

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

Identify all family members who have or have had any of the following:

_____ Alcoholism _____ Birth Defects _____ Heart Disease _____ Obesity
_____ Allergies _____ Cancer _____ Hearing Loss _____ Stroke
_____ Anemia _____ Diabetes _____ High Blood Pressure _____ Thyroid Disorder
_____ Arthritis _____ Eczema _____ Hypoglycemia _____ Other
_____ Asthma _____ Epilepsy _____ Mental Illness _____ Other

Does this patient have any of the above? _____

If yes, please list and describe:

_____

_____

_____

_____

PATIENT'S HEALTH HISTORY

Please list the health history of this infant/child/adolescent

Now	Past	Never		Now	Past	Never		Now	Past	Never	
___	___	___	Acne	___	___	___	Depression	___	___	___	High Fever
___	___	___	Allergies	___	___	___	Diarrhea	___	___	___	Hyperactivity
___	___	___	Anemia	___	___	___	Dizzy Spells	___	___	___	Insomnia
___	___	___	Asthma	___	___	___	Earaches	___	___	___	Jaundice
___	___	___	Bed Wetting	___	___	___	Eczema	___	___	___	Learning Disorder
___	___	___	Birth Defects	___	___	___	Epilepsy/ Seizures	___	___	___	Moodiness
___	___	___	Colic	___	___	___	Fatigue	___	___	___	Stuffy Nose
___	___	___	Constipation	___	___	___	Frequent Infections	___	___	___	Vomiting Spells
___	___	___	Cough/ Wheeze	___	___	___	Headaches	___	___	___	Other:
___	___	___	Cradle Cap	___	___	___	Heart Murmurs	___	___	___	Other:

What is your infant's/child's/adolescent's general disposition?

_____

_____

_____

PRENATAL, BIRTH AND FEEDING HISTORY

Pregnancy History:
Previous pregnancies by natural mother and any complications:

_____

_____

Mother's health during pregnancy: (check and describe below)

___ Age ___ Nausea ___ Toxemia ___ Stress ___ X-Rays ___ Alcohol Use ___ Smoking

___ Bleeding ___ Illness ___ Trauma/Injury ___ High Blood Pressure ___ Medications ___ Drugs ___ Other

Describe:

_____

_____

Pregnancy and Feeding Information:

Term: _____ Full _____ Premature _____ Late _____ Birth Weight
Was pregnancy: _____ Easy _____Difficult
Place of birth: _____ Hospital _____ Home _____ Clinic _____ Other: _____
Feeding: _____ Breast-fed How long? _____
_____ Formula-fed How long? _____ Type of formula: _____
_____ Cow's milk At what age? _____

Age solid foods began: _____ What foods? _____

Food allergy or intolerances: _____

Favorite foods: _____

Typical day diet: *(please include food and liquids)*

_____

_____

SOCIAL HISTORY

Parents: _____ Married _____ Domestic Partnership _____ Separated _____ Divorced

Mother's occupation: _____ Full / Part-time

Father's occupation: _____ Full / Part-time

Other Guardian (name): _____ Relationship: _____

Others residing in home: _____ Relationship: _____

Currently in: _____ Daycare _____ Preschool _____ School Where? _____

How many hrs/day? _____ How many days/wk? _____

Siblings:

Name	Age	Health Problems	Name	Age	Health Problems
1. _____	____	_____	4. _____	____	_____
2. _____	____	_____	5. _____	____	_____
3. _____	____	_____	6. _____	____	_____

Interaction with relatives: Who _____

How often? _____

_____

OTHER INFORMATION

Are there any other health concerns you would like to discuss? Please explain.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your patience, time, and cooperation!