

Patient History and Intake Form

DIRECTIONS: PLEASE FILL OUT THE FRONT PAGE AT EVERY VISIT

Date _____

If you need help completing this form, please ask a staff member for help. Give as many details as you know. **Please note that while we may not be able to address all of the health problems listed on this sheet during this clinic visit, our knowledge of them may help us deal with your child's needs more effectively.**

Your name: _____ Your relationship to child: _____

CURRENT HEALTH CONCERNS

Why are we seeing your child today? _____

My child has no other symptoms unless checked below

PLACE A CHECKMARK NEXT TO ANY SYMPTOM OR CONDITION YOUR CHILD CURRENTLY HAS

	How Long		How Long		How Long
Weakness/Tired	<input type="checkbox"/> _____	Trouble Seeing	<input type="checkbox"/> _____	Difficulty Gaining Weight	<input type="checkbox"/> _____
Fever/Chills	<input type="checkbox"/> _____	Hoarse Voice	<input type="checkbox"/> _____	Weight Loss	<input type="checkbox"/> _____
Seizures	<input type="checkbox"/> _____	Trouble Breathing	<input type="checkbox"/> _____	Poor Eating/Drinking	<input type="checkbox"/> _____
Trouble Sleeping	<input type="checkbox"/> _____	Wheeze	<input type="checkbox"/> _____	Eats/Drinks Too Much	<input type="checkbox"/> _____
Sleeps Too Much	<input type="checkbox"/> _____	Cough	<input type="checkbox"/> _____	Pain With Urination	<input type="checkbox"/> _____
Snoring	<input type="checkbox"/> _____	Chest Pain	<input type="checkbox"/> _____	Increased Urination	<input type="checkbox"/> _____
Headache	<input type="checkbox"/> _____	Rapid Heart Rate	<input type="checkbox"/> _____	Blood in Urine	<input type="checkbox"/> _____
Ear/Throat Pain	<input type="checkbox"/> _____	Heart Murmur	<input type="checkbox"/> _____	Irregular/Painful Periods	<input type="checkbox"/> _____
Trouble Swallowing/Chewing	<input type="checkbox"/> _____	Stomach Pain	<input type="checkbox"/> _____	Vaginal Discharge	<input type="checkbox"/> _____
Neck Pain/Swelling	<input type="checkbox"/> _____	Constipation	<input type="checkbox"/> _____	Joint/Leg/Arm Pain	<input type="checkbox"/> _____
Runny Nose	<input type="checkbox"/> _____	Vomiting	<input type="checkbox"/> _____	Easy Bruising	<input type="checkbox"/> _____
Eye Drainage/Redness	<input type="checkbox"/> _____	Diarrhea	<input type="checkbox"/> _____	Yellow Skin/Jaundice	<input type="checkbox"/> _____
Trouble Hearing	<input type="checkbox"/> _____	Blood in Stool	<input type="checkbox"/> _____	Rash/Skin Problems	<input type="checkbox"/> _____
<input type="checkbox"/> Other _____					

* Please continue on back if you are a new patient or a returning patient with changes to any section on the back.



Patient History and Intake

Patient Label

PLEASE COMPLETE IF YOU ARE A NEW PATIENT OR RETURNING PATIENT WITH CHANGES

CHILD'S HEALTH HISTORY

Was your child born early or on time? On time Early If early, how many weeks early? _____

Were there any problems in the pregnancy or delivery? No Yes If yes, please describe below:

How much did your child weigh at birth? _____ How many days did your child stay in the hospital after birth? _____

Has your child ever been hospitalized? No Yes If yes, please describe below:

Has your child had any operations? No Yes If yes, please list date and reason below:

Does your child have any other chronic conditions? No Yes If yes, please describe below:

Is your child allergic to anything (medicines, food, other)? No Yes If yes, please list below:

Do you have a primary care provider that handles your child's immunizations? No Yes

DEVELOPMENT/SCHOOL

Are there any concerns with your child's physical or mental development, mood, or behavior? No Yes If yes, please describe:

Is your child having a hard time with school or studying? No Yes If yes, please describe:

FAMILY HISTORY

Circle the condition and identify family members who have any of the following:

<i>Condition</i>	<i>Family member</i>	<i>Condition</i>	<i>Family member</i>
Heart Disease/High Blood Pressure/Stroke:	_____	Seizures or Headaches:	_____
Lung Disease/Asthma:	_____	Arthritis at a young age:	_____
Bleeding Problems/Cancer/Tumors:	_____	Any other history of family illnesses, diseases, early deaths?	_____
Kidney Disease or Diabetes:	_____		_____
Stomach or Intestine Disease:	_____		_____

HOME ENVIRONMENT

Is anyone living in the home sick? No Yes If yes, what are they sick with? Please describe below:

Are there pets or animals in the home? No Yes List types: _____

Has anyone in the home traveled outside the country recently? No Yes If yes, please list below:
Where? _____ When? _____

Were you or your child born in a country other than the United States? No Yes If yes, please list below:
Who? _____ What country? _____

Does anyone in the home have TB (tuberculosis) or other infections? No Yes If yes, who? _____

Does anyone smoke at home? No Yes

Is there a wood stove in the home? No Yes

What type of water do you have? City water Well water

PATIENT EDUCATION

In what ways do you prefer to learn about how to care for your child's medical needs?
 Reading (written materials or pictures) Listening (one-on-one conversation) Watching (demonstration) Doing (practicing myself)

Who else helps care for your child? _____

Do you have any needs (physical abilities, cultural, religion) related to your child's care that will help us work together better with your child and family? If so, please explain: _____

