CROWN

Clinical Records
On-Line Web Network

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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.

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CROWN Pediatric Intake Form Section 1

Child's Name________________________________ Today's Date______________
First Last

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)

Medication Name	Dose	When is it given?	Approximate start date of medication

Does your child take any non-prescription medications including vitamins or herbal supplements? Yes___No___
If yes, list:____

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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?________________________________

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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 Nevi: 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_____________