



dr.cory

### PEDIATRIC INTAKE FORM

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone (H) \_\_\_\_\_ (cell) \_\_\_\_\_

How did you hear about Dr Cory?  
\_\_\_\_\_

Name and Address of Dr.'s office/hospital/clinic where your child's health records are kept.  
\_\_\_\_\_

Reason for referral or presenting problem(s)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication History	MEDICATIONS			
	Now	Past	Now	Past
Aspirin	_____	_____	Antibiotics	_____
Tylenol	_____	_____	Anti-histamine	_____
Decongestant	_____	_____	Other	_____
Ibuprofen	_____	_____	Allergies to meds	_____

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

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

Childhood Illnesses:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chicken Pox            | <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Measles                | <input type="checkbox"/> Pneumonia                 | <input type="checkbox"/> Rubella             |
| <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Frequent colds            | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Tonsillitis, no. _____ | <input type="checkbox"/> Ear Infections, no. _____ |  |

Has your child ever had any of the following tests?

	<u>When</u>	<u>Where</u>	<u>Results</u>
EKG			
EEG			
Psychological Eval.			
Hearing			
Speech/language			

<b>IMMUNIZATIONS</b>				
<u>Vaccinations</u>				
<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> MMR	<input type="checkbox"/> Smallpox	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Mumps	<input type="checkbox"/> DPT	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Influenza	
<input type="checkbox"/> Other (list)				

<b>FAMILY HISTORY</b>			
<u>Family History</u>			
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies
<input type="checkbox"/> Mental illness			

Mother's age at child's birth? \_\_\_\_\_

Mother's health during pregnancy?

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Bleeding     | <input type="checkbox"/> Physical or emotional trauma          |
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Illnesses    | <input type="checkbox"/> Medications                           |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems                      |
| <input type="checkbox"/> Diabetes     |  |

Term: <input type="checkbox"/> Full <input type="checkbox"/> Premature	<b>BIRTH WEIGHT</b> at birth _____ lbs _____ oz
Length of labor _____ hours	Complications? _____

Has your child ever had any of the following problems?

- |  |                                   |   |                                    |
|--|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Birth defects  | <input type="checkbox"/> Rashes    |
| <input type="checkbox"/> Colic                 | <input type="checkbox"/> Fever    | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Blue baby             | <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth injuries |                                    |
| <input type="checkbox"/> Other (explain) _____ |                                   |   |                                    |

Child's sleep pattern (first year) \_\_\_\_\_

Food intolerance (if any) \_\_\_\_\_

Feeding: Breast fed?  How long? \_\_\_\_\_ Formula: Milk Soy Other \_\_\_\_\_

Age began solid foods \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Age said first words \_\_\_\_\_

**Medical History SYMPTOMS** (Mark  for current and P for past)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hives              | <input type="checkbox"/> Burning of urine   | <input type="checkbox"/> Bloody urine        |
| <input type="checkbox"/> Eczema             | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cries easily        |
| <input type="checkbox"/> Bleeding of gums   | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Nervous             |
| <input type="checkbox"/> Nose bleeds        | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Sleep problems      |
| <input type="checkbox"/> Acne               | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Night sweats        |
| <input type="checkbox"/> High fevers        | <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Sensitive to light  |
| <input type="checkbox"/> Chronic rash       | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Body/breath odor    |
| <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Easy bruising      | <input type="checkbox"/> Motion/car sickness |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Flat feet          | <input type="checkbox"/> No appetite         |
| <input type="checkbox"/> Sore throat        | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Nightmares          |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Gas                | <input type="checkbox"/> Canker sores        |
| <input type="checkbox"/> Frequent colds     | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Unusual fears       |
| <input type="checkbox"/> Wheezing           | <input type="checkbox"/> Joint pain         | <input type="checkbox"/> Excessive fatigue   |
| <input type="checkbox"/> Cough              | <input type="checkbox"/> Dizzy spells       | <input type="checkbox"/> Hair loss           |

**DIET**

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Is there any other information about your child's health you would like to add?

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Thank you for being thorough. I look forward to meeting you!

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