# COMPASSIONATE FAMILY MEDICINE
# PEDIATRIC PATIENT INTAKE FORM

**Welcome to Compassionate Family Medicine!** We are pleased to serve your health care needs and those of your family. In order to assist our providers and staff, please print clearly and complete the information below to the best of your ability.

**Patient Name**: _____ Sex: M F Date of Birth: ___/___/____ SS# _____

Address _____
Street City/Town State Zip Code

Home Phone: _____Cell Phone:_____ Social Security # _____

Insurance Carrier: _____ Policy Holder's Name:_____

Policy Number:_____Your relation to Policy Holder:_____Policy Holder SS#:_____

**I agree to allow Compassionate Family Medicine to send a bill for treatment(s) to my insurance carrier:**

**Patient/Guardian signature: _____ Date: _____/_____/_____**

## PARENT/GUARDIAN INFORMATION:

_____
Mother's Name Address (If different) Phone #

_____
Father's Name Address (If different) Phone #

**If different than above, please list below who is the Legal Guardian for this child/patient:**

_____(___ )_____
Name Relationship Address (If different) Phone number

_____(____)_____
Name Relationship Address (If different) Phone number

**Please explain any special circumstances regarding custody and parties involved in medical decision making:**

_____

_____

_____

Former Primary Care Provider _____(____)_____
Name Address Phone number

Please list below any specialists you see/have seen, contact information if possible:

_____

_____

## HEALTH MAINTENANCE HISTORY (Please indicate date of last exam/test)

| Exam | Date | Exam | Date |
|---|---|---|---|
| Routine Physical | | Dental Exam | |
| Lead Test | | Eye Exam | |

**Patient Name:**_____ **Date of Birth:** ___/____/_____

## PAST MEDICAL HISTORY **Check one for each box…..Yes or No**

| Condition | Y | N | Condition | Y | N | Condition | Y | N |
|---|---|---|---|---|---|---|---|---|
| ADHD | | | Fractures | | | Scoliosis | | |
| Allergies | | | Intestinal Disorder | | | Seizure Disorder | | |
| Asthma | | | Joint Disorder | | | Thyroid Disorder | | |
| Acne | | | Kidney/Urinary Disease | | | **List others below:** | | |
| Chicken Pox | | | Liver Disease | | | | | |
| Ear Infections | | | Meningitis | | | | | |
| Developmental Problems | | | Mental Illness | | | | | |
| Diabetes | | | Mononucleosis | | | | | |
| Eczema | | | Neurologic Disorder | | | | | |
| Eye Disease | | | Reflux | | | | | |

Please provide any additional details regarding those condition(s) above where you marked "yes":

_____

_____

_____

_____

## Birth History

Full Term____ Premature_____ Number of weeks _____ Type of Delivery _____

Pregnancy Complications _____ None___ Delivery Complications_____ None____

Jaundice - Yes___ No___ Hearing Test - Pass ___ Fail ___ Birth Weight: _____ Birth Length:_____

Received Hepatitis B vaccine in hospital? Yes ___ No___

## Allergies **(include reaction):**

_____

_____

_____

## Medications **(Includes birth control, over the counter, vitamins, supplements, and herbal remedies):**

Name Dose Frequency Reason For Use

_____

_____

_____

## Surgeries

Year Procedure Surgeon Facility_____

_____

_____

**Patient Name:**_____ **Date of Birth:** ___/____/_____

## Hospitalizations

Year Reason Facility (Name and address if out of local area)

_____

_____

_____

_____

## Personal Background

Current Grade Level _____ School _____

Special Needs/Services_____ None _____

Extracurricular Activities _____

Age of onset menstrual periods _____ Frequency _____ Duration ____

## Family History

Adopted ___ Unknown ___ Please list below any pertinent medical illnesses in the patient's family.

Father _____Mother_____

Brother(s) _____ Sister(s) _____

_____ _____

Paternal Grandfather_____ Paternal Grandmother_____

Maternal Grandfather _____ Maternal Grandmother_____

Additional Family Members – not listed above:

_____

**This Pediatric Intake Form has been completed to the best of my ability –**

**Signature of Parent/Guardian:**_____ **Date:** ___/____/_____