Dr. Anne Marie Palzer
PEDIATRIC INTAKE FORM

Patient Name:_____ DOB/Age:_____
Sex: ___Male ___Female Grade in School:_____
Mother's Name and Occupation:_____
Father's Name and Occupation:_____
Parents are: ___ Married ___Separated ___Divorced ___Living together ___Other
Reasons for office visit:_____
Has child been seen by any other doctors for this concern?: ___Yes ___No ___Past
Name of pediatrician and their location:_____

Last time child has blood work done and with which physician:_____
_____

List all child's surgeries and hospitalization with approximate date:
1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

List all medicines (from drugstore or prescription) child is currently using:_____
_____

List all supplements child is currently taking:_____
_____

List any known allergies to foods, drugs, environment, or animals:_____
_____

PREVIOUS MEDICAL HISTORY

*YES indicates the child gets the problem regularly
*NO indicates the child has never had the problem
*PAST indicates the child had the problem in the past but not recently

Ear infections: __yes __no __past How many total:_____
Colds: __yes __no __past How many total:_____
Strep throat __yes __no __past How many total:_____
How many times has the child taken antibiotics?_____
What other medications has the child taken and how often?_____
_____

Hearing tests normal: __yes __no __not tested
Vision tests normal: __yes __no __not tested
Speech impediments: __yes __no __past
Learning disabilities: __yes __no __past

VACCINATION HISTORY

MMR: __yes __no __some DPT: __yes __no __some
Hib: __yes __no __some Polio: __yes __no __some
Hep B:__yes __no __some Chicken pox: __yes __no __some
Other:_____
Any reactions to vaccinations?_____

FAMILY HISTORY

Allergies:	__yes __no __past	Tuberculosis:	__yes __no __past
Diabetes mellitus:	__yes __no __past	Obesity:	__yes __no __past
Mental illness:	__yes __no __past	Cancer:	__yes __no __past
Cardiovascular Dz:	__yes __no __past	Other:_____	

MOTHER'S PREGNANCY HISTORY

Age at conception:_____ Did mother have other children previously? __yes __no

Health During Pregnancy

Smoking: __yes __no Coffee: __yes __no Traumatic birth: __yes __no
Nausea/vomiting: __yes __no Diabetes: __yes __no Pre-eclampsia: __yes __no
Emotional stress: __yes __no Vaginal birth: __yes __no Drug use: __yes __no

Length of labor:_____ If birth was difficult, please explain:_____
_____

Health of baby at birth:_____

HEALTH HISTORY OF CHILD

Child breastfed: __yes __no For how long?_____ When put on formula:_____

What type of formula?_____ When were solid foods begun?_____

When did child walk?_____ Talk?_____ Develop teeth?_____

Jaundice as baby:	__yes __no	Colic:	__yes __no
Cradle cap:	__yes __no	Anemia:	__yes __no
Eczema/Psoriasis:	__yes __no	Asthma:	__yes __no
Diarrhea:	__yes __no	Warts:	__yes __no
Constipation:	__yes __no	Nightmares:	__yes __no
Picky eater:	__yes __no	Bed-wetting:	__yes __no
Poor teeth:	__yes __no	Tantrums:	__yes __no
Chronic sniffles:	__yes __no	Disobedient:	__yes __no
Bad foot odor:	__yes __no	Fears/Phobias:	__yes __no
Diaper rash:	__yes __no	Early puberty:	__yes __no
ADD/HD:	__yes __no	Stomach aches :	__yes __no
Growing pains:	__yes __no		

Additional comments:_____
_____
_____

Parent or Guardian's Name_____

Signature of Parent or Guardian_____Date_____