Monterey County Health Department

Pediatric Intake Form

Child's Name: _____

Mother's Name: _____ Father's Name: _____

Referred by: _____ Regular or Previous _____

Birth Information

Yes	No	(Circle or fill in as appropriate)
		Born at CHOMP, Natividad, Home, other hospital
		Prenatal Care? Where?
		Birth Weight: Birth Length:
		Problems with pregnancy? What?
		Born at 9 months? How early or late?
		Delivery: Vaginal delivery? Vacuum assist or C-section? Why?
		Problems at birth?
		Length of hospital stay? Days
		First diet: breast and/or bottle

Past Medical History

Yes	No	(Circle or fill in as appropriate)
		Medical Problems?
		Last doctor visit - date: Why?
		Last ER visit - date: Why?
		Last time you stayed in hospital - date: Where? Why?
		Other hospitalizations? Why?
		Ever had pneumonia? If yes how many times?
		Past surgeries? Why?
		Number of ear infections in last 12 months?
		Allergies to medicines? Which?
		Allergies to foods? Which?
		Medications and doses?
		Ever had a dental exam? How long since last dental exam?
		Using folk medicines/practices? What type?
		Taking vitamins? Taking iron? Taking fluoride? Taking herbs?
		Has your child been a victim of physical, sexual, or emotional abuse?

Development:

Yes	No	(Circle or fill in as appropriate)
		Are you aware of any developmental problems? What?
		Age first sat?
		Age first walked without help?
		Age said first meaningful word?
		Does disciplining your child include hitting?
		Is bed wetting a problem? Age first used toilet?
		Do you have questions about using discipline to teach you child?
		Does your child have trouble controlling his or her temper?
		Child's educational level: Typical grades in school: A B C D F Ever in special Ed?
		How many hours of TV does your child watch each day?
		Do you have any questions about puberty? What?
		Age Menses started? Are they regular? No Yes Usually
		Age became sexually active? Last Pap smear date?

Illness Prevention:

Yes	No	Unsure	(Circle or fill in as appropriate)
			Date of last physical exam?
			Are the vaccinations up to date?
			Has your child had chicken-pox?
			Has your child been vaccinated for chicken-pox?
			Has your child had Hepatitis B vaccine?
			Any smokers in the family?
			Are there working smoke detectors in your home?
			Are there guns in your home?
			Does your child use a car seat or seat belt?
			Does your infant sleep on it's back (not side or front)?
			Are pills, drugs, and matches out of reach in your home?
			Does your child know your phone number and address?
			Does your child know how to swim?
			Does your child brush his/her teeth?
			Does your child floss his/her teeth?
			Does your child eat vegetables?
			Does your child eat fruits?
			Do you have questions about street drugs?

Social History

How many people live in your home? _____ What languages are spoken? _____

Parents are: ___Living together _____ separated _____ divorced

Family History

Father's age: _____ Illnesses: _____

Mother's age: _____ Illnesses: _____

Brothers and Sisters:

Name:	Date of Birth	Illnesses

Yes	No	Does anyone in your child's family have? If you check yes say if they are mother, father, sister, uncle, aunt
		Birth Defects
		Cancer
		Diabetes
		Stroke
		Epilepsy
		High Blood Pressure
		Tuberculosis
		Heart Trouble
		Kidney Problems
		Mental Retardation
		Suicide
		Insanity
		Drug or Alcohol problems?
		Violence problems or gang problems?

I certify the above history is complete and correct to the best of my knowledge. Updated: _____

Signature _____ _____

_____

_____