DES MOINES UNIVERSITY

Pediatric Intake Form~ Ages 0-16 Years

Date _____

Name _____

Date of Birth _____

Signature of Parent or Guardian:

_____

Sex ☐ Male ☐ Female

Milestones **Age**

Rolling Over _____

Sitting Up _____

Walked _____

Talked _____

Social History

Smoke Exposure	YES	NO
Pet Exposure	YES	NO
City Water (Fluorinated)	YES	NO
Day Care	YES	NO

Sports

Football	Volleyball	Basketball
Hockey	Baseball	Softball
Soccer	Gymnastics	

Current Medications

(include prescription and over the counter drugs, birth control, herbal medications, and vitamins)

Medication **Dosage/How Often**

1. _____ _____
2. _____ _____
3. _____ _____

Allergies **Reaction**

_____ _____

_____ _____

_____ _____

Are immunizations up to date? YES NO

(Please provide our office with a copy)

Social History for adolescents

DRUG/ALCOHOL USE	YES	NO
Do you or have you ever smoked?		
If yes, how many cigarettes a day?		
If former smoker, when did you quit?		
If former smoker, how long did you smoke?		
Do you drink alcohol?		
Average Use Per Week:		
Do you use illegal drugs?		
If yes, what type(s)?		
How much and how often?		
If no, have you used illegal drugs in the past? (Please indicate type/how much/how often)		
Do you drink caffeine?		
If yes, how much per day?		
Do you exercise?		
If yes, what activity?		
How many days per week?		
Time/duration (minutes)?		
Are you sexually active		
Do you have a history of sexually transmitted diseases?		

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Check if the PATIENT has had or currently has any of the following

Past Medical History

Anemia			Eczema		
Anesthesia Problems			Eye Disease		
Asthma			Frequent Colds		
Anxiety			Heart Disease		
Back Pain			Joint Pain		
Bleeding Disorders			Kidney Disease		
Blood Clots			Murmur		
Blood Transfusions			Physical Abuse		
Broken Bones			Pneumonia		
Cancer			Reflux		
Type:			Seasonal Allergies		
Chicken Pox			Sexual Abuse		
Colic			Thyroid Disease		
Depression			Tonsillitis		
Diabetes					
Ear Infections					

Comments on Past Medical History

_____

_____

Hospitalizations

Date (mm/year) Reason

____/____ _____

____/____ _____

____/____ _____

Birth and Development

Full Term YES NO

Delivery Vaginal C-Section Complicated

Pregnancy Problems (please explain)

_____

_____

Birth Weight _____

Discharge Weight _____

Jaundice YES NO

:

Gynecologic History (Females Only)

Age at first period _____

Other menstrual history _____

_____

Past Surgical History

Please check the box if Patient has had the surgery and then indicate the year if you know it.

SURGERY	Y	YEAR
Appendix		
Back Surgery		
Ears		
Eyes		
Foot		
Hernia repair		
Joint		
Tonsils		
Wisdom teeth		

Other Surgical History

Surgery Year

_____ _____

_____

Testing

	DATE	NORMAL RESULTS	
Lead		Yes ☐	No ☐
TB		Yes ☐	No ☐
Hearing		Yes ☐	No ☐
Eye exam		Yes ☐	No ☐
Dental exam		Yes ☐	No ☐

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Family History

Family Member	Age if Living	Age Deceased	Cause of Death
Mother			
Father			
Maternal Grandmother Paternal			
Maternal Grandfather Paternal			
Sibling			

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

M=Mother F=Father S=Sibling

DISEASE/COND.	M	F	S	S	S
Alcoholism					
AIDS					
Alzheimer's					
Anemia					
Anesthesia Problems					
Anxiety					
Asthma					
Bleeding Disorders					
Blood Clots					
Cancer					
Type:					
Depression					
Diabetes					
Emphysema					
Glaucoma					
Heart Disease					
Hemorrhoids					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Migraines					
Osteoporosis					
Seizures					
Stroke					
Thyroid Disease					
Tuberculosis (TB)					

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

GMM=Maternal grandmother
GFM=Maternal grandfather
GMP=Paternal grandmother
GFP=Paternal grandfather

DISEASE/COND.	GMM	GFM	GMP	GFP
Alcoholism				
AIDS				
Alzheimer's				
Anemia				
Anesthesia Problems				
Anxiety				
Asthma				
Bleeding Disorders				
Blood Clots				
Cancer				
Type:				
Depression				
Diabetes				
Emphysema				
Glaucoma				
Heart Disease				
Hemorrhoids				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Migraines				
Osteoporosis				
Seizures				
Stroke				
Thyroid Disease				
Tuberculosis (TB)				

Additional Comments on Family History:_____