Dr. Camille Nghiem-Phu, BSc, ND

PEDIATRIC INTAKE FORM

Last name:_____ First name and initial: _____
Parent(s)/Guardian(s): _____
Address: _____
City: _____ Province: _____ Postal Code: ____-____
Telephone: (___) ___-____ Date of birth: yyyy/mm/dd Sex: M F
Height: _____ Weight: _____
Emergency contact: _____ Relationship: _____
Emergency contact phone: (___) ___-____

Name of present MD: _____Phone (___) ____-_____
Address of present MD: _____

Chief complaints:
_____
_____
_____
_____
Date of onset: yyyy/mm/dd
Onset was: sudden / gradual / associated with an event: _____

Maternal Health and Birth History:
Term: premature / full / late Duration of pregnancy: _____ weeks
Labour duration: _____ Induced labour: Y / N
Location: □hospital □birthing centre □home Type: □medical □midwife
Delivery: vaginal / C-section / breech / forceps
APGAR at birth: _____ APGAR at 5 minutes: _____
Birth weight: _____ Birth length: _____

Problems patient had at birth:
□breathing □colouring □choking
□crying □nursing □sleeping
□jaundice □other:_____
Was the infant alert and responsive within 12 hours of delivery? Y / N _____

Any birth trauma?
□bruises □odd shaped head □stuck in birth canal
□cord around neck □respiratory depression □fast or excessively long labour
□other: _____

Item(s) applied to patient at birth:
□medication □artificial feeding □Vitamin K
□surgery □erythromycin □circumcision
□other: _____

Maternal condition:
pregnancies: _____ # live births: _____ # lost pregnancies: _____
maternal age at patient's birth: _____ weight gain during pregnancy: _____
paternal age at conception: _____

Maternal complications:
□hypertension □gestational diabetes □toxemia
□vaginal bleeding □premature labour □vomiting
□other: _____

Maternal health during pregnancy:
□STDs (herpes/chlamydia/syphilis/trichomonas) □HIV
□cigarettes □cocaine □alcohol
□marijuana □varicella □other: _____
Exercise habits during pregnancy: _____
Stresses during pregnancy (physical/emotional): _____
_____
Cravings during pregnancy: _____

Maternal medications during pregnancy:
Prescription: _____
Over the counter: _____
Nutritional supplements: _____

Childhood Medical Health of Patient:
Past Childhood Illnesses:
□asthma □chicken pox □croup □ear infection
□eczema □tuberculosis □whooping cough □rubella (german measles)
□herpes □impetigo □lyme disease □measles
□meningitis □mononucleosis □mumps □pink eye
□pinworms □pneumonia □poison ivy/oak □poliomyelitis
□ringworm □roseola □rheumatic fever □tetanus
□thrush (fungal infection in the mouth from a Candida infection)
□toxoplasmosis □epilepsy/convulsions

Vaccination:
□hepatitis B □DTP (diptheria, tetanus, pertussis)
□HiB (also called HbCV) □IPV (injected polio vaccine)
□OPV (oral polio vaccine) □MMR (measles, mumps, rubella)
□varivax (chicken pox vaccine)
Any reactions to the vaccines, and if so, what kind? _____
_____

Growth and development:
At what age did the patient:
respond to sound _____ follow on object _____
hold head up _____ vocalize _____
sit alone _____ teethe _____
crawl _____ walk _____

Do sleeping patterns seem normal to you? Y / N
Explain: _____

Feeding History:
Was baby breast fed? Y / N How long? _____
Formula was introduced at age _____ Type of formula used _____
Introduction of cow's milk at age _____ Began solid foods at age _____
Type of solid foods introduced _____
Age and type of commercial baby food introduced _____
Any intolerances? Y / N explain: _____
Any cravings? _____
Is the child a picky eater? Y / N explain: _____

Childhood Drug History:
Any antibiotics? Y / N total number of courses of antibiotics: _____
Other medications? Y / N
1-Medication: _____ for: _____
Length of time on drug:_____
Reactions to drug? _____
2-Medication: _____ for: _____
Length of time on drug:_____
Reactions to drug? _____
Supplements: _____

Past hospitalizations: _____
_____
Past surgeries: _____
_____

Family Medical History:
Please indicate by noting **M** (mother), **F** (father), **S** (sibling), **PGM** (paternal grandmother), **MGM** (maternal grandmother), **PGF** (paternal grand father), **MGF** (maternal grandfather)
Allergy, asthma or eczema _____ Liver disease _____
Cancer _____ Mental condition _____
Diabetes or low blood sugar _____ Mental illness _____
Heart trouble _____ Ulcer _____
High blood pressure/stroke _____ Kidney disease _____
Other: _____

Social influences and behaviours:
Who lives at home? _____
Any pets? Y / N If yes, what? _____ How long? _____
Any smokers at home? Y / N If yes, who? _____
Any behavioural problems? Y / N Onset: _____
Any night terrors, sleep walking, difficulty sleeping? Y / N
Explain: _____
Age of child when began daycare: _____
Average number of hours of television/computer/video games per week: _____
Any difficulty with social interaction? Y / N explain: _____
Extra-curricular activites / hobbies: _____

Exercise habits: _____
Do the parent(s) / guardian(s) work? Y / N Who? _____
How many hours a week? _____ Number of hours spent with child per week _____
How old is the home? _____ How is it heated? _____
Any recent home renovations? _____
How long have you been in the present home? _____
Is it located near: □trees □powerlines □highways □industry
□other: _____

General Review of Systems:

Does your child have any rashes, lumps, sores, itching, dry skin, change in hair or nails?
Y / N If yes: _____
Has your child ever been unconscious, had a convulsion, have recurring headaches or had a head injury?
Y / N If yes: _____
Any problems with hearing, ringing in the ears, dizziness, ear infections, discharge?
Y / N If yes: _____
Any problems with teeth, gums, tongue, sore throats or hoarseness?
Y / N If yes: _____
Any problem with their eyes, including vision?
Y / N If yes: _____
Has your child ever been cyanotic (turned blue), have a cough, wheeze, or asthma?
Y / N If yes: _____
Any recurring problem with vomiting, diarrhea, constipation or stomach pain?
Y / N If yes: _____
Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance to the urine?
Y / N If yes: _____
Does your child complain of any extremity or lower back pain? Y / N
Do you notice a limp, or unusual gait pattern?
Y / N If yes: _____
Has your child ever had blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tremors, or other involuntary movements?
Y / N If yes: _____
Does your child have any thyroid trouble, excessive thirst or hunger, heat or cold intolerance, or diabetes?
Y / N If yes: _____
Any allergies, eczema, hay fever, hives or drug reactions?
Y / N If yes: _____
Does you child have any intense fears, mood swings, or other sensitivities?
Y / N If yes: _____

OTHER HEALTH CONCERNS & ADDITIONAL INFORMATION:

_____
_____
_____
_____
_____