PEDIATRIC MEDICAL INTAKE FORM (Ages 0-17) rev 2/1/18

Name_____ **Date**_____ **Date of Birth** _____

Phone Number_____

Person to contact in case of Emergency_____Relationship to you _____

Emergency contact number_____

Reason for Visit: ACNE RASH MOLE CHECK **Other:**

_____ **Primary Care Doctor**
(name & city)

_____

ALLERGIES:

_____**Allergy**
to LATEX: YES NO

Medication (Including over-the-counter medications & supplements) **Dose, How many times a day;**

(Example – Vitamin Z 200mg *1 tablet*
twice a day)

_____

_____

_____

_____

_____

_____

FAMILY history of SKIN CANCER? NO YES RELATION/TYPE: _____

PATIENT MEDICAL HISTORY - CIRCLE ALL THAT APPLY:
SKIN CANCER (type, body location + date): _____

HEART: High Blood Pressure High Cholesterol Heart Attack Artificial Valves/MVP Heart Failure Irregular Heart Beat Heart Murmur Pacemaker Defibrillator Bypass or Open Heart Surgery Other_____

LUNG: Asthma Emphysema COPD Other_____

PSYCHIATRIC: Anxiety Depression Bipolar Disorder Other_____

BLOOD: Bleeding problems Easily Bruise Anemia Other_____

MUSCLE/BONES: Arthritis Joint Replacement (specify which joint & year):_____
Other_____
INFECTIOUS DISEASE: HIV Hepatitis Tuberculosis Other_____

GENITOURINARY: Kidney Disease Dialysis Other_____

STOMACH: Ulcer Reflux Irritable Bowel Other _____

NEUROLOGICAL: Seizure Stroke/TIA Migraine Other_____

ENDOCRINE: Diabetes Hypothyroid Hyperthyroid Other_____

EYES: Glaucoma Cataracts Macular Degeneration Other _____

EARS: Decreased Hearing Hearing Aids Other _____

CANCER (please specify):_____

PREVIOUS SURGERY (please specify): _____

Do you take ANTIBIOTICS before dental work? YES NO

Does patient smoke (cigarettes, cigars, pipe, etc)? **NO** **Check if patient NEVER smoked** _____

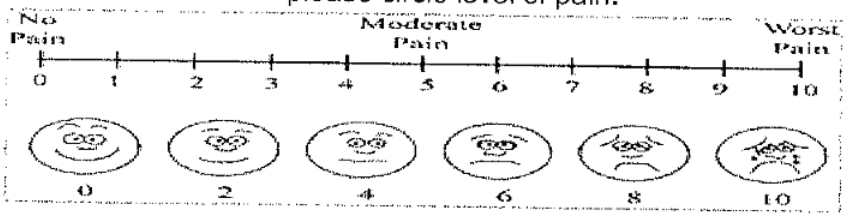
IF YES How much? 2-3 per month 2-3 per week less than 1 pack per day 1+ packs per day

Former smoker? YES Year started_____ Year quit_____

Does patient drink alcohol? YES NO/NEVER

Are you having pain today? ***NO*** ***YES*** If yes, where? _____

please circle level of pain:



Has patient had a Flu Vaccine? ***NO*** ***YES*** When: _____

Has patient had a Pneumonia vaccine? ***NO*** ***YES*** When: _____

Has patient had one dose of meningococcal vaccine between the 11th and 13th birthdays? ***NO*** ***YES***

Has patient had one tetanus, diphtheria toxoids, and acellular pertussis (t-dap) vaccine between the 10th and 13th birthdays? ***NO*** ***YES***

Has patient had at least 3 HPV vaccines between the 9th and 13th birthdays? ***NO*** ***YES***

Does patient have a history of psoriasis or psoriatic arthritis? ***NO*** ***YES*** If yes, has patient been tested for TB? YEAR: _____ Result _____

FEMALES – circle any that apply: **currently pregnant** **nursing** **planning pregnancy**

PRESCRIPTION & PHARMACY INFORMATION

PHARMACY NAME: _____ ***PHONE NUMBER:*** _____

ADDRESS *(street & city):*

_____