Patient Name: _____

Date of Birth: _____

Date: _____

Newport Children's Medical Group

PATIENT INTAKE HISTORY

Pregnancy and Birth History

Problems during pregnancy:	☐ no	☐ yes
Medications	☐ no	☐ yes
Smoking/alcohol/drugs	☐ no	☐ yes
Diabetes	☐ no	☐ yes
Illness during pregnancy	☐ no	☐ yes
Other	☐ no	☐ yes

Delivery: ☐ Vaginal ☐ Cesarean section

Reason for C/S: _____

☐ Full Term ☐ Premature (#mos _____)

Birth Weight _____ Birth length _____

Problems immediately after birth:

Infection	☐ no	☐ yes
Breathing difficulty	☐ no	☐ yes
Jaundice	☐ no	☐ yes
Home with mother	☐ no	☐ yes

Other: _____

Medical History

Current Medications _____

_____

Medication allergies _____

Food allergies _____

Hospitalizations

_____

Previous infections/problems:

Anemia	☐ no	☐ yes	_____
Asthma	☐ no	☐ yes	_____
Bedwetting	☐ no	☐ yes	_____
Behavior problem	☐ no	☐ yes	
Bladder or Kidney infection	☐ no	☐ yes	_____
Chicken Pox	☐ no	☐ yes	_____
Constipation	☐ no	☐ yes	_____
Convulsions or seizures	☐ no	☐ yes	_____
Ear infection	☐ no	☐ yes	_____
Eczema	☐ no	☐ yes	_____
Hay fever	☐ no	☐ yes	_____
Hearing Problem	☐ no	☐ yes	_____
Learning problems	☐ no	☐ yes	_____
Pneumonia	☐ no	☐ yes	_____
Sleep problems	☐ no	☐ yes	_____
Transfusion	☐ no	☐ yes	_____
Vision problems	☐ no	☐ yes	_____
Weight problem	☐ no	☐ yes	_____

Other _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____

Developmental History

Child was able to do the following at what age:

Smile _____

Role over _____

Sit alone _____

Crawl _____

Walk alone _____

First words _____

Toilet Trained _____

Family History

Alcohol or drug problem	☐ no	☐ yes
Allergies	☐ no	☐ yes
Asthma	☐ no	☐ yes
Birth defects	☐ no	☐ yes
Blood diseases	☐ no	☐ yes
Blindness	☐ no	☐ yes
Cancer	☐ no	☐ yes
Convulsions	☐ no	☐ yes
Elevated cholesterol/trigly	☐ no	☐ yes
Deafness	☐ no	☐ yes
Death in childhood (incl SIDS)	☐ no	☐ yes
Diabetes	☐ no	☐ yes
Headaches/migraines	☐ no	☐ yes
Heart defects (incl congenital)	☐ no	☐ yes
Heart attacks	☐ no	☐ yes
At what age: _____		
Hypertension	☐ no	☐ yes
Immune deficiency (incl AIDS)	☐ no	☐ yes
Learning problems	☐ no	☐ yes
Liver disease	☐ no	☐ yes
Lung disease	☐ no	☐ yes
Mental retardation	☐ no	☐ yes
Psychiatric disorders	☐ no	☐ yes
Thyroid disease	☐ no	☐ yes
Tb test – positive results	☐ no	☐ yes

Conditions that run in the family: _____

_____

_____

Social History

Exposure to passive smoke	☐ no	☐ yes
Smoker in household	☐ no	☐ yes

Household Parent/Caretaker

Name	Age	Employer
_____	_____	_____
_____	_____	_____

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____

Others in Home

Name	Age	Relation to Patient
_____	_____	_____
_____	_____	_____

Others important in adolescent's life

Name	Age	Employer
_____	_____	_____
_____	_____	_____

This information has been reviewed with the patient:

Signature: _____ Date: _____