

**PATIENT INTAKE FORM
AND CLINICAL INFORMATION**

Name _____
Date Of Birth _____
MRN# _____
Account/HAR# _____
PATIENT IDENTIFICATION

Patient's Name _____ Preferred Name _____

First Middle Last
Date of Birth _____ Sex check one ☐ M ☐ F
Month Day Year

REASON FOR TODAY'S VISIT

☐ Follow-up Describe/Comment _____

☐ New Problem Describe/Comment _____

When did the problem begin _____ Comments: _____
Month Day Year

Current _____ Current _____

Weight Pounds Ounces Height Feet Inches

Pediatrician (Name) _____ Phone # _____

Does your child see any specialists or have medical follow up appointments? ☐ Yes ☐ No If so, list below:

Physician Name _____ Specialty _____ Phone # _____

Physician Name _____ Specialty _____ Phone # _____

Do you have any allergies? ☐ Yes ☐ No If so, list below:

Allergies	Reaction and Severity
_____	_____
_____	_____
_____	_____

Do you take any medications, vitamins, or supplements? ☐ Yes ☐ No If so, list below:

Medications, Vitamins, Supplements	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Patient Lives With: ☐ Mother ☐ Father ☐ Other _____

Primary Caregiver: ☐ Mother ☐ Father ☐ Other _____

Do you have siblings? ☐ Yes ☐ No If yes, list ages _____

With Patient Today: ☐ Mother ☐ Father ☐ Other _____

Daytime Childcare: ☐ Home with Parent ☐ In Home Daycare ☐ Home Based Daycare ☐ Group Daycare ☐ School ☐ Other _____

NORTHSIDE NEONATAL SURGERY

A Northside Provider

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GENERAL INFORMATION

Is there a smoker living in the home? ☐ Yes ☐ No

Is your child allergic to latex? ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

What type of pets live in the home of the child? Please describe _____

Does your child: ☐ Swallow pills ☐ Prefer liquids

Does your home utilize: ☐ City water ☐ Well water

Has the patient ever been hospitalized? ☐ Yes ☐ No

List past hospitalizations Where _____ When _____

Where _____ When _____

Prior Anesthesia ☐ Yes ☐ No ☐ Complications If so, explain: _____

BIRTH INFORMATION

Birth Weight pounds _____ ounces _____ Weeks Early _____ OR Weeks Gestation _____ Discharge Weight _____

Problems with Pregnancy

☐ Preterm Labor ☐ Pre-eclampsia/Eclampsia ☐ Other _____

☐ Gestational Diabetes ☐ Bleeding Problems

MEDICAL HISTORY

No medical history to report: ☐

ADHD ☐ Yes ☐ No Developmental Delay ☐ Yes ☐ No Jaundice ☐ Yes ☐ No

Asthma ☐ Yes ☐ No Diabetes Mellitus ☐ Yes ☐ No Pneumonia ☐ Yes ☐ No

Bleeding Disorder ☐ Yes ☐ No Down Syndrome ☐ Yes ☐ No Seizures ☐ Yes ☐ No

Cancer ☐ Yes ☐ No Heart Murmur/Defect ☐ Yes ☐ No Sickie Cell Anemia/Trait ☐ Yes ☐ No

Cerebral Palsy ☐ Yes ☐ No HIV/AIDS ☐ Yes ☐ No RSV ☐ Yes ☐ No

Cystic Fibrosis ☐ Yes ☐ No Hydrocephalus ☐ Yes ☐ No Meconium Aspiration ☐ Yes ☐ No

Eye Problems/ROP ☐ Yes ☐ No Urinary Tract Infection/Urinary Reflux ☐ Yes ☐ No

Other Medical History _____

Please describe

SURGICAL HISTORY

No surgical history to report: ☐

Adenoidectomy ☐ Yes ☐ No Gastrostomy ☐ Yes ☐ No Tympanostomy ☐ Yes ☐ No

Appendectomy ☐ Yes ☐ No Lymph Node Biopsy ☐ Yes ☐ No VP Shunt ☐ Yes ☐ No

Atrial Septal Defect ☐ Yes ☐ No Tonsillectomy ☐ Yes ☐ No Ventricular Septal Defect ☐ Yes ☐ No

Port / CVL Placement ☐ Yes ☐ No Exploratory Laparotomy ☐ Yes ☐ No Tumor Excision ☐ Yes ☐ No

Eye Surgery ☐ Yes ☐ No Circumcision ☐ Yes ☐ No

Other Surgical History _____

Please describe

NUTRITION

FEED TYPE	ROUTE	AMOUNT	FREQUENCY
-----------	-------	--------	-----------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

FAMILY HISTORY

No family history to report: ☐

Please explain below if any family member has any of the following: Anesthesia or Bleeding Problems, Cancer, Dev Disability, Genetic Disorder, or Sickie Cell

Relationship	Condition
--------------	-----------

_____	_____
-------	-------

_____	_____
-------	-------

_____	_____
-------	-------

_____	_____
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REVIEW OF SYSTEMS

Please check the appropriate box(es) below if your child has any of the following:

GENERAL

- | | | | |
|---|--------------------------------------|---|---------------------------------------|
| ☐ Fever | ☐ Weight Loss | ☐ Change in Activity | ☐ Poor Feeding |
| ☐ Sleeping Problem | ☐ Chills | ☐ Fatigue | |
| ☐ Other _____ | | | |

HEAD/NECK

- | | | | |
|--------------------------------------|--|--------------------------------------|--------------------------------------|
| ☐ Headache | ☐ Vision Problems | ☐ Ear Pain | ☐ Sore Throat |
| ☐ Runny Nose | ☐ Eye Discharge | ☐ Nose Bleeds | ☐ Drooling |
| ☐ Other _____ | | | |

HEART OR BLOOD PROBLEMS

- | | | | |
|--|--|--|--|
| ☐ Heart Defect/Murmur | ☐ Bleeding Problems | ☐ Immune Deficiencies | ☐ Color Change With Feeding |
| ☐ Chest Pain | ☐ Sickle Cell Disease/Trait | ☐ Shortness of Breath | ☐ Fainting |
| ☐ Other _____ | | | |

RESPIRATORY PROBLEMS

- | | | | |
|---|--|--------------------------------|--------------------------------|
| ☐ Asthma/Wheezing | ☐ Cystic Fibrosis | ☐ Croup | ☐ Cough |
| ☐ Chronic Bronchitis | ☐ Noisy Breathing | | |
| ☐ Other _____ | | | |

DIGESTIVE SYSTEM PROBLEMS

- | | | | |
|--|--|---|--|
| ☐ Hepatitis | ☐ Gastric Reflux (GERD) | ☐ Constipation | ☐ Abdominal/Bloody Stools |
| ☐ Intestines/Bowels | ☐ Diarrhea | ☐ Feeding Problems | ☐ Liver |
| ☐ Nausea/Vomiting | ☐ Abdominal Pain | | |
| ☐ Other _____ | | | |

NERVOUS SYSTEM PROBLEMS

- | | | | |
|--|---|--|--|
| ☐ Convulsions, Seizures or Fits | ☐ Down's Syndrome | ☐ Developmental Delay | ☐ Speech Delay |
| ☐ Cerebral Palsy | ☐ Myelomeningocele | ☐ Learning Disability | ☐ Poor Coordination |
| ☐ Hydrocephalus | | | |
| ☐ Other _____ | | | |

KIDNEY or BLADDER PROBLEMS

- | | | | |
|--|---|---|----------------------------------|
| ☐ Urinary Tract Infection | ☐ Urinary Reflux | ☐ Groin Swelling | ☐ Dysuria |
| ☐ Abnormal Kidney | ☐ Hematuria | ☐ Scrotal Swelling | |
| ☐ Other _____ | | | |

ENDOCRINE PROBLEMS

- | | | | |
|--------------------------------------|--|----------------------------------|--|
| ☐ Diabetes | ☐ Heat/Cold Intolerance | ☐ Thyroid | ☐ Growth Issues |
| ☐ Other _____ | | | |

SKIN PROBLEMS

- | | | | |
|---|----------------------------------|--|--|
| ☐ Rash | ☐ Eczema | ☐ Nipple Discharge/Pain | ☐ Wound |
| ☐ Hives | ☐ Itching | ☐ Birthmark/Mole | ☐ Bruising Problems |
| ☐ Location _____ | | | |

PSYCHIATRIC PROBLEMS

- | | | |
|---|---|--|
| ☐ Behavior problem | ☐ Depression | ☐ Clingy |
| ☐ Hyperactive | ☐ Sleep Disturbance | ☐ Fussy |
| ☐ Nervous/Anxiety | ☐ Attention Problems | ☐ Decreased Energy Levels |
| ☐ Other _____ | | |

IMMUNE PROBLEMS

- | | | | |
|---|--|---------------------------------|---------------------------------------|
| ☐ Recurrent Skin Infection | ☐ Immune Deficiencies | ☐ Cancer | ☐ Chemotherapy |
| ☐ Other _____ | | | |