SWEDISH MEDICAL GROUP

Initial Pediatric Intake Form

Pediatric Health History **Swedish Pediatrics** **Today's Date: / /**

Child's Name:_____ Child's Date of Birth: _____/_____/_____ Child's Age: _____
Last First MI

Parent's Name(s)_____

_____

Preferred NICKNAME for child? _____

Who has legal custody of the child if not both parents?

_____

Patient lives with (please mark all that apply): □Father □Mother □Sibling(s)

Are the patient's **parents**: □ Married □ Domestic Partners □ Unmarried □ Widowed
□ Separated □ Divorced If divorced or separated, when? _____

Please list all family members or others who live with the patient. **If the patient lives with one parent and visits the other, please provide Information for both homes. Please continue on reverse if more space needed.**

Name	Date of birth	Relationship	Occupation / comments

Communication

May we leave a detailed message for you that may contain health information or lab results? ☐ Yes ☐ No

If yes, what number(s) may we use to leave the message? _____

Immunizations

Has your child had recommended immunizations? □ Yes □ No

If no, why not? _____

Has there been any reaction to prior immunizations? □ Yes □ No

If yes, what? _____

Have all household members been immunized against pertussis (whooping cough)? □ Yes □ No

Pregnancy and Birth ☐ If born at Swedish do not fill out

1. Birth weight _____ Born at full term (on time)? □ Yes □ No Weeks:_____
2. Birth Place _____
3. Problems in pregnancy or labor and delivery: □ None
   _____
4. 4. Medications during pregnancy? □ None
   _____
5. Smoking or alcohol use during pregnancy? □ Yes □ No
   _____
6. Problems for baby at birth or shortly after birth: □ None
   _____

Medications

Current Medications (timing and dose): □ None □ see MEDLIST
Vitamins: □ Yes □ No Fluoride: □ Yes □ No

_____ _____
_____ _____
_____ _____

Allergies (list drug and/or food and reaction):
□ None

_____
_____
_____

CURRENT MEDICAL ISSUES □ None

_____

_____

Previous Surgeries: _____

Previous Hospitalizations: _____

Previous Healthcare Providers: _____

Past Medical History

Has your child ever had any of the following issues? **Please check if "yes"**

	Yes	Date(s)		Yes	Date(s)
Anemia			Pneumonia		
Asthma/Wheezing			School Problems		
Bowel /GI Issues			Serious Accidents		
Broken Bones			Sleeping Problems		
Chicken Pox			Urination Issues/ UTI		
Convulsions / Seizures			3+ Episodes of Ear Infections		
Dental Problems			3+ Throat Infections in a Year		
Hearing Problems			Other:		
Heart Issues/ Murmur					

Family Health History

If your child has other siblings with the same family history please list below:

Name: _____ Date of Birth: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

Please include **ONLY** immediate family – Parents, Siblings, and Grandparents **Please check if "yes"**

□ Patient is adopted □ Family history is unknown

M = Mother, F = Father, B = Brother, S = Sister, MGM = Maternal Grand Mother, MGF = Maternal Grandfather

Condition	**Yes**	**If yes, relationship to patient**	**Details**
Abnormal heart valve			
Allergies			
Amblyopia (Lazy eye)			
Asthma			
Atopic dermatitis / Eczema			
Attention Deficit ADD / ADHD			
Autism			
Birth defects			
Cancer			
Clotting or bleeding disorder			
Developmental Delay / disability			
Diabetes (specify type if known)			
Hearing loss before age 50			
Heart arrhythmia			
Heart attack before age 50			
High blood pressure			
High cholesterol			
Kidney disease			
Newborn hip dysplasia (dislocation)			
Psychiatric Illness (Depression, Bipolar, etc.)			
Seizures			
Sudden unexplained death			
Suicide			
Thyroid disorder			
Other:			

Parent/Guardian Signature:_____ Date:_____