EAST TENNESSEE Children's Hospital

Pediatric Clinic

NEW PATIENT MEDICAL HISTORY INTAKE FORM

BIRTH HISTORY:

Child's name: Date of birth:

Born at: Gestational age: ( ) full term ( ) weeks

Delivery: ( ) natural ( ) vacuum assist
( ) spontaneous ( ) forceps assist
( ) induced ( ) C-section

Birth weight: Discharge weight:
Birth length:
Mom's blood type (if known):
Infant blood type (if known):
Group B strep status ( ) pos ( ) neg ( ) unknown

PREGNANCY HISTORY

			Comments:
Pregnancy complications	( ) yes	( ) no	_____
High blood pressure	( ) yes	( ) no	_____
Gestational diabetes	( ) yes	( ) no	_____
Tobacco use	( ) yes	( ) no	_____
Alcohol use	( ) yes	( ) no	_____
Other drugs	( ) yes	( ) no	_____

Birth compications ( ) yes ( ) no Comments

PAST MEDICAL HISTORY:

Prior hospitalizations: ( ) yes ( ) no Comments:
Prior surgeries: ( ) yes ( ) no Comments:

Allergies: _____

Please list any medical issues or chronic illness that your child has:

FAMILY HISTORY:

Please indicate if there is a family member with any of the following conditions:

Condition:			Family member(s) affected:
Asthma	( ) yes	( ) no	_____
Heart disease	( ) yes	( ) no	_____
Heart attack	( ) yes	( ) no	_____
Diabetes	( ) yes	( ) no	_____
Seizures	( ) yes	( ) no	_____
Blood disorders	( ) yes	( ) no	_____
High blood pressure	( ) yes	( ) no	_____
Mental illness	( ) yes	( ) no	_____
Cancer	( ) yes	( ) no	_____
Kidney disease	( ) yes	( ) no	_____
Other disease(s)	( ) yes	( ) no	Comments:
No know healt problems in family:		( )	

REVIEW OF SYSTEMS

Please note if your child is having any of the following problems:

CONSTITUTIONAL			Comments:
Fatigue	( ) yes	( ) no	_____
Appetite changes	( ) yes	( ) no	_____
Sleep distrubance	( ) yes	( ) no	_____
Fever	( ) yes	( ) no	_____
OPHTHALMOLOGIC			
Eye redness	( ) yes	( ) no	_____
Discharge	( ) yes	( ) no	_____
Swelling	( ) yes	( ) no	_____
ORAL			
Dental problems	( ) yes	( ) no	_____
ENT			
Swollen tonsils	( ) yes	( ) no	_____
Sore throat	( ) yes	( ) no	_____
Hoarseness	( ) yes	( ) no	_____
Runny nose	( ) yes	( ) no	_____
Nosebleeds	( ) yes	( ) no	_____
Ear pain	( ) yes	( ) no	_____

Ear drainage	( ) yes	( ) no	_____
Hearing loss	( ) yes	( ) no	_____
Sinusitis	( ) yes	( ) no	_____

RESPIRATORY

Cough (daytime)	( ) yes	( ) no	_____
Cough (night-time)	( ) yes	( ) no	_____
Difficulty breathing	( ) yes	( ) no	_____
Wheezing	( ) yes	( ) no	_____

CARDIOVASCULAR

			Comments:
Exercise intolerance	( ) yes	( ) no	_____
Fainting	( ) yes	( ) no	_____
Palpitations/racing heart	( ) yes	( ) no	_____
Chest pain	( ) yes	( ) no	_____

GASTROINTESTINAL

Abdominal pain	( ) yes	( ) no	_____
constipation	( ) yes	( ) no	_____
diarrhea	( ) yes	( ) no	_____
blood in stool	( ) yes	( ) no	_____

HEMATOLOGY

Easy bleeding	( ) yes	( ) no	_____
Easy bruising	( ) yes	( ) no	_____
Easy blood clotting	( ) yes	( ) no	_____

GENITOURINARY

Painful urination	( ) yes	( ) no	_____
Frequent urination	( ) yes	( ) no	_____
Bedwetting	( ) yes	( ) no	_____

MUSCULOSKELETAL

Joint swelling	( ) yes	( ) no	_____
Joint pain	( ) yes	( ) no	_____

SKIN

Rash	( ) yes	( ) no	_____
Acne	( ) yes	( ) no	_____
Skin infection	( ) yes	( ) no	_____
Eczema	( ) yes	( ) no	_____

NEUROLOGIC

Seizures	( ) yes	( ) no	_____
Headaches	( ) yes	( ) no	_____

PSYCHIATRIC

Depressive symptoms	( ) yes	( ) no	_____
Difficulty concentrating	( ) yes	( ) no	_____
Difficulty sitting still	( ) yes	( ) no	_____

Parent/Caregiver signature: _____

Date:

_____