CROWN
Clinical Records
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Pediatric Intake Form

Our Philosophy of Patient Care

We thank you for taking the time to complete the following medical history. We realize this may seem like a lot of information, especially if your condition does not seem related. However, we believe that it is important to have complete knowledge and understanding of your medical background in order to care for you and treat you properly. Many seemingly unrelated symptoms, points of family history, environmental exposures and many other factors can all contribute to your well-being. A thorough medical history is also required by Medicare and insurance companies, in accordance with government standards. This information will be compiled and entered into our electronic health record and will be available to other providers you may see in this facility. All patient information is kept confidential based on HIPAA Guidelines. It takes time to treat everyone properly and thoroughly. We ask for your patience while you are waiting to be seen. Thank you, ColumbiaDoctors.

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CROWN Pediatric Intake Form Section 1

Child's Name_____ Today's Date_____
First Last

Date of Birth___/____/____ Age _____ Gender M / F

Patient's Address _____

Telephone number _____ Mobile or alternate number _____

Parent/Guardian Information: (Please check if address is the same as patients: ____)

Parent 1 Name:_____ Parent 2 Name: _____

Date of Birth: _____ Date of Birth: _____

Address: _____ Address:_____

_____ _____

Phone Number:_____ Phone Number: _____

Work Number: _____ Work Number: _____

Mobile Number: _____ Mobile Number: _____

Insurance: _____ Insurance: _____

Insurance I.D.#: _____ Insurance I.D. #: _____

Ok to leave message on voicemail of above provided numbers (may contain personal health information)?

Home: Yes_____No_____ Mobile: Yes____No_____

Referring Physician_____

Please list your child's pediatrician's name, address, and phone #:_____

_____

Preferred Pharmacy_____Pharmacy Phone_____

Pharmacy Address_____

What is the reason for your child's visit today?_____

If your child's problem causes pain, where is it painful?_____How long has it been present?_____

Description of pain_____When does it occur?_____Severity_____

Any other symptoms?_____What makes it better or worse?_____

Does your child have any medication allergies? Yes___No___ If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _____

Does your child have any other allergies? Please list:_____

Is your child allergic to latex? Yes___No____ _____

Please list ALL of your child's current medications below (use back of page if you need more room)

Medication Name	Dose	When is it given?	Approximate start date of medication

Does your child take any non-prescription medications including vitamins or herbal supplements? Yes___No___
If yes, list:_____

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CROWN Pediatric Intake Form Section 1

Child's Name_____Date of Birth_____

BIRTH HISTORY:

How many weeks gestation at birth?_____Birth weight_____Which pregnancy is this child? _____

Did mother have health problems during the pregnancy? Yes__No__ Describe:_____

Born by vaginal delivery or c/section?_____ If c/section, reason:_____

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc)_____

_____

Is your child adopted? Yes__No__ If Yes, *please describe the above to the best of your knowledge*.

MEDICAL HISTORY: HAS YOUR CHILD EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING (describe)?:

Anemia:	Yes__No__	_____
Asthma/Breathing Problems:	Yes__No__	_____
Allergies:	Yes__No__	_____
Arthritis:	Yes__No__	_____
Behavioral Problems:	Yes__No__	_____
Bleeding Tendency:	Yes__No__	_____
Bowel Problems:	Yes__No__	_____
Cancer/Leukemia:	Yes__No__	_____
Chicken Pox/Shingles:	Yes__No__	_____
Developmental Disorder:	Yes__No__	_____
Diabetes:	Yes__No__	_____
Ear/Nose/Throat (ENT) Disorder:	Yes__No__	_____
Eczema/Skin Disorder:	Yes__No__	_____
Eye Disorder:	Yes__No__	_____
Growth Disorder:	Yes__No__	_____
Heart Disorder/Defect:	Yes__No__	_____
High Blood Pressure:	Yes__No__	_____
High Cholesterol:	Yes__No__	_____
Immune Deficiency Disorder:	Yes__ No__	_____
Kidney/Urinary Disorder:	Yes__No__	_____
Liver Disease:	Yes__No__	_____
Seizure:	Yes__No__	_____
Thyroid Disorder:	Yes__No__	_____
Any Other?	Yes__No__	_____

SURGICAL HISTORY: List any surgeries your child has had and the approximate date:

_____

Has your child had a blood transfusion? Yes_No_____? If yes, when?_____

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CROWN Pediatric Intake Form Section 1

Child's Name_____Date of Birth_____

FAMILY HISTORY: Does your child have any family members with a history of major illness or conditions? List below:

		Relationship to Patient
Atopic Dermatitis (Eczema):	Yes__No__	_____
Asthma:	Yes__ No__	_____
Seasonal Allergies:	Yes__No__	_____
Psoriasis:	Yes__No__	_____
Skin Cancer:	Yes__No__	_____
Melanoma:	Yes__ No__	_____
Dysplastic Nevi:	Yes__No__	_____
Scarring Acne:	Yes__No__	_____

Other: _____

SOCIAL HISTORY:
Parent's Name: _____Marital Status:_____Parent's Occupation:_____
Parent's Name: _____Marital Status:_____Parent's Occupation:_____
Legal Guardian, if other than parents:_____
Other people living in the home: _____
Does your child or anyone living in your home smoke? Yes____No_____
Have you ever had problems with lead paint or contamination in your home? Yes_____No_____
Do you have pets in your home? Yes_____No_____If Yes, what types?_____
Do you have other children? Yes ____No____ If Yes, how many? _____What are their ages? _____

For female patients if applicable:
Age at first menses? _____ Last menstrual period? _____ Are your child's menses regular? _____

REVIEW OF SYSTEMS (For each system, please CIRCLE any/all that apply within PAST MONTH or NONE if applicable):
Constitutional: Fever Chills Feeling Poorly Feeling Tired Recent Weight Gain Recent Weight Loss **NONE**
Eyes: Eye Pain Red Eyes Itchy Eyes Discharge from Eyes Eyesight Problems Dry Eyes **NONE**
ENT: Ear Ache Loss of Hearing Nosebleeds Nasal Discharge Sore Throat Hoarseness **NONE**
Cardiovascular: Chest Pain Palpitations Fast Heart Rate Slow Heart Rate Leg Claudication Leg Swelling **NONE**
Respiratory: Shortness of Breath Wheezing Cough Trouble Breathing with Exertion Trouble Breathing When Flat **NONE**
Gastrointestinal: Nausea Vomiting Diarrhea Constipation Heartburn Blood in Stool Abdominal Pain **NONE**
Genitourinary: Pain with Urination Trouble Urinating Genital Discharge Abnormal Vaginal Bleeding (if applicable) **NONE**
Musculoskeletal: Joint Pain Joint Stiffness Joint Swelling Limb Pain Limb Swelling **NONE**
Integumentary: Skin Lesions Skin Wound Itching Change in a Mole Breast Pain Breast Lump **NONE**
Neurological: Confusion Convulsions Dizziness Fainting Limb Weakness Difficulty Walking **NONE**
Psychiatric: Suicidal Sleep Disturbance Anxiety Depression Change in Personality Emotional Problems **NONE**
Endocrine: Muscle Weakness Feelings of Weakness Hot Flashes Deepening of the Voice **NONE**
Heme/Lymph: Easy Bruising Easy Bleeding Swollen Glands **NONE**
Other (Please Explain) _____

Parent/Guardian Signature_____**Date**_____

FOR OFFICE USE ONLY: *CROWN-7-29-13 intake*

I have reviewed all sections of the intake form and entered relevant information as applicable into CROWN.
Physician Signature_____Date_____