

GREEN MOUNTAIN MEDICINE • DR. MIKA TSONGAS
THE OLD POWERHOUSE • 120 E LAKE ST, STE 205, SANDPOINT, IDAHO 83864
MTSONGAS@GREENMTMED.COM • 208-255-1951

PEDIATRIC INTAKE FORM (6 to 12 years old)

Name of patient: _____ Date _____

Age _____ Date of Birth / / _____ Female _____ Male _____

Mother's name _____ Father's name _____

Other parenting partner(s) _____

Sibling(s), including age(s) _____

Physical Address _____

Mailing Address _____

Email _____

City _____ State _____ Zip Code _____

Telephone: Home _____ Work _____ Cell _____

How did you hear about this clinic? _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

<u>Condition</u>	<u>Past Treatment</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	Ear infections	Y N	approx. # in lifetime	_____
Measles	Y N	Tonsillitis	Y N	approx. # in lifetime	_____
German measles	Y N	Other (please list)	_____		
Chicken pox	Y N	_____			

PLEASE COMPLETE BOTH SIDES OF EACH PAGE

Previous Testing

Has your child had any of the following tests? When Where
Electroencephalogram (EEG) _____
Psychological evaluation _____
Hearing tests _____
Speech/Language tests _____

Hospitalizations/ Surgeries/ Injuries

Please list hospitalizations, surgeries or injuries for your child:

Immunizations

Polio Y N Pertussis Y N
Tetanus shot Y N Diphtheria Y N
Measles/Mumps/Rubella Y N Influenza Y N
Any adverse reactions to vaccines? Y N If yes, what? _____

Allergies

In the following categories, list any substances to which your child is hypersensitive or allergic:
Drugs _____
Foods _____
Environmental substances _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking.

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

REVIEW OF SYSTEMS

Y = a condition now P = a condition in the past N = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N
----------	---	---	---	------------------	---	---	---

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hay fever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

