

GREEN MOUNTAIN MEDICINE • DR. MIKA TSONGAS
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PEDIATRIC INTAKE FORM (Birth to 5 years old)

Patient's name _____ Date of first visit _____
 Age _____ Date of birth _____ Gender: female ___ male ___
 Mother's name _____ Father's name _____
 Other parenting partner(s) _____
 Physical Address _____ City _____ State ___ Zip code ___
 Mailing Address _____ City _____ State ___ Zip code ___
 Home/cell phone _____ Parent's work _____ Email _____
 How did you hear about this clinic? _____
 Reason for referral or presenting problems _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis, approx. number	_____
_____ Measles	_____ Pneumonia	_____ Ear infections, no.	_____
_____ Mumps	_____ Frequent colds	_____ other (please list)	_____
_____ Rubella	_____ Rheumatic fever		

Has your child had any of the following tests? When Where Results

Electroencephalogram	_____	_____	_____
Psychological evaluation	_____	_____	_____
Hearing	_____	_____	_____
Speech/Language	_____	_____	_____

Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

_____ Measles	_____ Polio	_____ MMR	_____ Smallpox	_____ Diphtheria
_____ Mumps	_____ DPT	_____ Tetanus	_____ Influenza	

Others (list) _____

Any adverse reactions to vaccines? Y N Please specify: _____

FAMILY HISTORY

_____ Heart disease	_____ Diabetes	_____ Birth defects
_____ Hypertension	_____ Arthritis	_____ Tuberculosis
_____ Cancer	_____ Allergies	_____ Mental illness

PLEASE COMPLETE BOTH SIDES

PRENATAL HISTORY

Please specify any previous pregnancies by natural mother, any miscarriages or other complications with pregnancy:

Mother's age at child's birth? _____

Mother's health during pregnancy:

- | | | |
|--------------------|-------------------------------------|-------------------|
| _____ Bleeding | _____ Physical or emotional trauma | _____ Illnesses |
| _____ Nausea | _____ Cigarettes, alcohol, drug use | _____ Medications |
| _____ Hypertension | _____ Thyroid problems | _____ Diabetes |

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

- | | | |
|----------------------|----------------------|-----------------|
| _____ Birth defects | _____ Birth injuries | _____ Blue baby |
| _____ Cerebral palsy | _____ Seizures | _____ Jaundice |
| _____ Colic | _____ Fever | _____ Rashes |

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast-fed? _____ how long? _____ Formula? _____ milk/soy/other _____

Age began solids _____ which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** for current and **P** for past symptoms)

- | | | |
|----------------------|--------------------------|---------------------------|
| _____ Hives | _____ Burning of urine | _____ Bloody urine |
| _____ Eczema | _____ Frequent urination | _____ Cries easily |
| _____ Bleeding gums | _____ Heart murmur | _____ Nervous |
| _____ Nosebleeds | _____ Vomiting spells | _____ Sleep problems |
| _____ Acne | _____ Anemia | _____ Night sweats |
| _____ High fevers | _____ Stomach aches | _____ Sensitive to light |
| _____ Chronic rash | _____ Jaundice | _____ Body/breath odor |
| _____ Hearing loss | _____ Easy bruising | _____ Motion/car sickness |
| _____ Diarrhea | _____ Flat feet | _____ No appetite |
| _____ Sore throats | _____ Constipation | _____ Nightmares |
| _____ Headaches | _____ Gas | _____ Canker sores |
| _____ Frequent colds | _____ Bleeding tendency | _____ Unusual fears |
| _____ Wheezing | _____ Joint pains | _____ Excessive fatigue |
| _____ Cough | _____ Dizzy spells | _____ Hair loss |

Other symptoms or chronic conditions: _____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Welcome! We're glad to be of service to you and your child.