GREEN MOUNTAIN MEDICINE • DR. MIKA TSONGAS
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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) ____

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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.

Condition Past Treatment

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

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

CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N

URINARY

Frequent urination	Y P N	Bed wetting	Y P N

GASTROINTESTINAL

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel Movements	How often ___________________________________		

MUSCULOSKELETAL

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y P N	Easy bleeding/bruising	Y P N

Is there any information about your child's health that you would like to add? ________________

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