GREEN MOUNTAIN MEDICINE
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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	_____	_____			

Please list any known allergies to medicines, food or environmental substances:

Current supplements: _____

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): _____
_____

PLEASE COMPLETE BOTH SIDES OF EACH PAGE

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

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.