

PEDIATRIC HEALTH HISTORY

Dr. Leah McNeill  
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Bellevue, WA 98005 (P)425-881-2310

PATIENT NAME: \_\_\_\_\_

**Confidential Pediatric Intake form to be filled out by parent or legal guardian**

**TODAY'S DATE:**

**CHILD'S FULL NAME:**

**DATE OF BIRTH:**

**PREFERS TO BE CALLED:**

**SEX:     M     F**

**Date of last complete check up:**

**HEIGHT:**

**WEIGHT:**

**Major Complaint**

What brings you in for this initial visit? If a diagnosis was made, please indicate date of diagnosis and who or where it was diagnosed.

Are there any areas you would like to work on?

How would you rate the General Health of your child: (1 being Poor; 10 being Excellent):

Is your child on any Medications, Homeopathics, or Supplements (including vitamins and herbs)?  
(Please list dosages)

Any Allergies to medications?

Allergies to other substances (foods, inhalants, etc)

How was the pregnancy and childbirth for birth mom?

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Any difficulties for child following birth?

Has your child experienced any major childhood illnesses, accidents, hospitalizations or surgeries?  
(Please include dates and child's age at the time)

### Immunizations and date if known

DTP	Yes	No	When:	Polio	Yes	No	When:
MMR	Yes	No	When:	Hepatitis B	Yes	No	When:
HbCV	Yes	No	When:	Chickenpox	Yes	No	When:
Other							

### Siblings

Name	Age	General Health:	Poor	Fair	Good
Name	Age	General Health:	Poor	Fair	Good
Name	Age	General Health:	Poor	Fair	Good

additional:

What are some of your child's favorite activities/hobbies?

Does your child have any fears?

What are your child's favorite foods and how often are they eaten?

What type of pets do you have?

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PATIENT NAME: \_\_\_\_\_

Does anyone in the house smoke?    Yes        No

How many hours of TV and video/computer games does your child engage in daily?

How would you rate your child's academic performance? (if appropriate)

Poor                  Fair                  Good                  Excellent

Is there anything else you feel we should know about your child?

**Family History:** check all that apply and indicate family member's relation to you (i.e.; maternal aunt). If family member has passed away from any of the following, please indicate their approximate age at the time of their passing.

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Alcoholism   |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Cancer (type)  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Other neurological disease (indicate)  |
| <input type="checkbox"/> Heart attack        |   |
| <input type="checkbox"/> Thyroid disorders   | <input type="checkbox"/> Chronic Gastrointestinal Disease (i.e.; Cohn's Disease, Ulcerative Colitis, Peptic Ulcers, Reflux) |
| <input type="checkbox"/> Alzheimer's disease |   |
| <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Emphysema (or other chronic respiratory disorder)  |
| <input type="checkbox"/> High Cholesterol    |   |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Chronic Skin condition (i.e.; Psoriasis, eczema, rosacea)  |
| <input type="checkbox"/> Asthma              |   |
| <input type="checkbox"/> Depression          |   |