SUNRISE FAMILY MEDICINE, PLLC
DR. TUAN M. VO, DO, MPH

PEDIATRIC/Adolescent Medical Intake Form

Please answer to the best of your knowledge and if applicable.

Please mark **NA** not applicable. Do not leave areas blank.

Child's Name:_____Date:_____

Birthday(M/D/Y):_____Current Age (M/Y):_____

Birthplace:_____

Home Address:_____

Guardian (title) #1 phone: _____

Guardian (title) #2 phone: _____

Current School:_____

School Address: _____

School Number:_____

Main Teacher/Principal:_____

Grade:_____ Type of Classes: (Regular/ED/GATE, etc):_____

FAMILY INFORMATION

Father or Guardian #1 (name/age/highest education degree):

Bio____/adoptive_____/step_____/foster_____

Current Occupation:_____

Address/Phone if different than above:_____

Mother or Guardian #2 (name/age/highest education degree):

Bio_____/adoptive_____/step_____/foster_____

Current Occupation:_____

Address/Phone if different than above:_____

Parent's Marital Status

Current: Married_____ Separated_____Divorced_____

Other Children in the Home:

Name/Relationship to child/Age/Grade:_____

Name/Relationship to child/Age/Grade:_____

Name/Relationship to child/Age/Grade:_____

Others Living in the Home:

Name/Relationship to child/Age:_____

Name/Relationship to child/Age:_____

Name/Relationship to child/Age:_____

Please List Treating Clinicians:

_____

_____

_____

_____

Primary Care Provider:_____

REASON FOR BEING HERE:

Current issues: What brings you here? Please list and describe your child's current problems starting with the most serious.

_____
_____
_____
_____
_____

Onset: When did the problems begin? How old was the child? What started it? Any major stresses happening in the family at the time the problems began?

_____
_____
_____
_____
_____

Treatment: What interventions have been tried including medications, therapy, or other nontraditional treatments?

Family Relationships: What effects have the problem had on family relationships and functioning? How does your child get along with each parent and sibling?

School: Describe your child's function at school. Are there any problems? What are their school related likes and dislikes?

Peer relationships: How does your child get along with other children? Who are their best friends? Have their problems affected these relationships?

CHILD's MEDICAL HISTORY

Medication Allergies, please list any life-threatening allergies :

Medication/Food Intolerances:

Food allergies:

_____
_____
_____
_____

List Current Medications/Vitamins/Herbs/Supplements including when it was started, doses, frequency, and reason child is taking the substance.

_____
_____
_____
_____
_____

Are Immunizations up to date? ____Yes_____No_____Not Sure_____

Please list if your child has or currently uses any chemical substances which may include: alcohol, tobacco, illicit substances, over-the-counter medications and prescriptions mediations.

_____
_____
_____
_____

Has the child ever been in trouble at home, school or with the law because of substance use? Please describe.

_____
_____
_____
_____

List past illnesses, timeframe, including treatments.

_____
_____
_____
_____
_____

List current medical illnesses, including date of onset, duration of illness and treatments.

_____
_____
_____
_____
_____

List past surgeries, including date of surgery, reason.

_____
_____
_____
_____

List any past hospitalizations, time frame, cause and treatments.

_____
_____
_____
_____

List all past injuries including head, bodily injury, treatment and outcomes.

_____
_____
_____
_____

PAST MENTAL HEALTH ISSUES

Has your child ever been treated for any psychological or psychiatric problems? Please describe any prior interventions.

_____
_____
_____
_____

Any history of being bullied, or bullying at school, home or online?

_____
_____
_____
_____

Any behavior issues or changes in the past?

_____
_____
_____
_____

How is your child's general health currently? _____

(Please Check/Fill where appropriate.)

HEARING:

Did your child have recurrent or chronic ear infections? __Yes_____No_____Not Sure_____

Did he/she require surgery and/or tube placement? __Yes_____No_____Not Sure_____

Has your child ever had a hearing problem? __Yes_____No_____Not Sure_____

Has anyone ever questioned your child's ability to hear? __Yes_____No_____Not Sure_____

VISION:

Has your child ever had eye or vision problems? __Yes_____No_____Not Sure_____

Has your child been treated for strabismus or "lazy eye"? __Yes_____No_____Not Sure_____

Has your child ever had any type of eye or vision therapy? __Yes_____No_____Not Sure_____

Does your child wear prescription glasses or contacts? __Yes_____No_____Not Sure_____

NEUROLOGICAL PROBLEMS:

Has your child had:

Severe headaches__Yes_____No_____Not Sure_____

Seizures__Yes_____No_____Not Sure_____

Seizures only with high fevers __Yes_____No_____Not Sure_____

Encephalitis __Yes_____No_____Not Sure_____

Meningitis__Yes_____No_____Not Sure_____

Loss of consciousness or black outs__Yes_____No_____Not Sure_____

Fainting__Yes_____No_____Not Sure_____

Momentary lapses of consciousness__Yes_____No_____Not Sure_____

Trance-like episodes__Yes_____No_____Not Sure_____

Chronic dizziness __Yes_____No_____Not Sure_____

Double vision __Yes_____No_____Not Sure_____

Tremor __Yes_____No_____Not Sure_____

Unexplained poor coordination __Yes_____No_____Not Sure_____

Trouble walking __Yes_____No_____Not Sure_____

Memory problems __Yes_____No_____Not Sure_____

TOXIC or DANGEROUS CHEMICAL/MATERIAL EXPOSURE :

has your child been exposed to:

Insulation__Yes__No__Not Sure__ Asbestos__Yes__No__Not Sure__

Fumes__Yes__No__Not Sure__ Metals__Yes__No__Not Sure__

Leads__Yes__No__Not Sure__ Mercury__Yes__No__Not Sure__

Chemicals__Yes__No__Not Sure__ Plastics__Yes__No__Not Sure__

Solvents__Yes__No__Not Sure__ Dyes__Yes__No__Not Sure__

TRAVEL:

Has your child traveled to a foreign country in the last 10 years?

__Yes_____No_____Not Sure_____

Where_____When_____

Where_____When_____

Where_____When_____

Does your child now, or in the past had a problem with:

Head Now__ Past__ Never__ Explain_____

Eyes Now__ Past__ Never__ Explain_____

Ears Now__ Past__ Never__ Explain_____

Nose Now__ Past__ Never__ Explain_____

Throat Now__ Past__ Never__ Explain_____

Respiratory Now__ Past__ Never__ Explain_____

Chest Now__ Past__ Never__ Explain_____

Heart or blood vessels Now__ Past__ Never__ Explain_____

Digestive tract Now__ Past__ Never__ Explain_____

Liver Now__ Past__ Never__ Explain_____

Genito urinary Now__ Past__ Never__ Explain_____

Bones Now__ Past__ Never__ Explain_____

Muscles Now__ Past__ Never__ Explain_____

Hormones Now__ Past__ Never__ Explain_____

Brain/nerves Now☐ Past☐ Never☐ Explain_____

Sleep Now☐ Past☐ Never☐ Explain_____

Appetite Now☐ Past☐ Never☐ Explain_____

Girls:

Age first menstrual period: _____

Is menstruation regular?_____

Any difficulties related to menstruation? Explain.

_____

Is your child sexually active? Yes ☐ No☐ Not Sure ☐

Does your child have a regular boyfriend or girlfriend? Yes ☐ No☐ Not Sure ☐

Anything else we should know about your child's medical history?

_____

FAMILY MEDICAL HISTORY (Please Check)

List: Name/Health (good/poor/died/age);Illness or cause of death/age

Father_____

Mother_____

Brother(s)_____

Sister(s)_____

Have any of the child's relatives had any of the following: (Y/N/relationship to child)

Migraine/chronic headaches Y☐N☐ R_____

Seizure, epilepsy Y☐N☐ R_____

Stroke Y☐N☐ R_____

High, low blood pressure Y☐N☐R_____

Heart Disease Y☐N☐R_____

Heart Attack Y☐N☐R_____

Heart Murmur Y☐N☐ R_____

Tuberculosis Y☐N☐R_____

Emphysema Y☐N☐ R_____

Lung Disease Y☐N☐ R_____

Asthma Y☐N☐ R_____

Hay Fever Y☐N☐R_____

Stomach Ulcers Y☐N☐R_____

Acid Reflux Y☐N☐R_____

Gallstones Y☐N☐ R_____

Diabetes Y☐N☐ R_____

High Cholesterol Y☐N☐ R_____

Liver Disease Y☐N☐ R_____

Hepatitis Y☐N☐ R_____

Kidney or renal disease Y☐N☐ R_____

Nephritis Y☐N☐ R_____

Thyroid disease Y☐N☐ R_____

Arthritis Y☐N☐ R_____

Obesity Y☐N☐ R_____

Infectious Disease Y☐N☐ R_____

HIV/AIDS Y☐N☐ R_____

Glaucoma Y☐N☐ R_____

Gout Y☐N☐ R_____

Anemia Y☐N☐ R_____

Allergies Y☐N☐ R_____

Hemophilia/ Bleeding Tendency Y☐N☐ R_____

Sudden unexplained death Y☐N☐ R_____

Alzheimer's Disease Y☐N☐ R_____

Dementia Y☐N☐ R_____

Cancer Y☐N☐ R_____

Genetic Disorder Y☐N☐ R_____

FAMILY PSYCHIATRIC HISTORY (Please Check)

Have any of your child's relatives had any of the following: Y/N/Relationship to child

Depression Y☐N☐ R_____

Manic Depressive (Bipolar) Disorder Y☐N☐ R_____

Post partum depression Y☐N☐ R_____

Post partum psychosis Y☐N☐R_____

Suicide Y☐N☐R_____

Anxiety Y☐N☐ R_____

Separation anxiety Y☐N☐ R_____

Agoraphobia Y☐N☐ R_____

Other Phobias Y☐N☐ R_____

Obsessive Compulsive Disorder Y☐N☐ R_____

PTSD Y☐N☐ R_____

Other stress disorder Y☐N☐ R_____

Anorexia Y☐N☐ R_____

Bulimia Y☐N☐ R_____

Other psychotic disorder Y☐N☐ R_____

ADHD Y☐N☐ R_____

ADD Y☐N☐ R_____

Oppositional Defiant Disorder Y☐N☐ R_____

Conduct Disorder Y☐N☐ R_____

Antisocial Personality Disorder Y☐N☐ R_____

Tourette's Disorder Y☐N☐ R_____

Other Tic Disorder Y☐N☐ R_____

Autism Y☐N☐ R_____

Asperger's Disorder Y☐N☐ R_____

Other Pervasive Developmental Disorder Y☐N☐ R_____

Alcoholism Y☐N☐ R_____

Substance Abuse Y☐N☐ R_____

Psychiatric Hospitalizations Y☐N☐ R_____

Have any family or relatives experienced: Y/N/Relationship

School problems Y☐N☐ R_____

Learning disabilities Y☐N☐ R_____

Dyslexia Y☐N☐ R_____

CHILD's DEVELOPMENTAL HISTORY

PREGNANCY (Please Check)

Did the child's biological mother have any difficulties during pregnancy? ☐

Spotting, bleeding, needing bed rest, special treatment ☐

Excess nausea, vomiting greater than 3 months ☐

Weight gain more than 30 pounds ☐

Weight gain under 20 pounds ☐

High blood pressure or excess swelling ☐

Convulsions during pregnancy ☐

Toxemia ☐

Pre-eclampsia ☐

Gestational Diabetes ☐

Threatened miscarriage or early contractions ☐

Accidents needing medical care ☐

Infection needing medical care ☐

Illness needing medical care ☐

Anemia ☐

Diabetes ☐

Heart Disease ☐

Kidney Disease ☐

Measles ☐

Flu or other virus ☐

Exposure to radiation/X rays etc ☐

Pregnancy considered high risk? ☐

Maternal age over 40 years ☐

Maternal age under 20 years ☐

Pregnancy shorter than 38 weeks ☐

Pregnancy longer than 42 weeks ☐

Medications were prescribed during pregnancy, if so which ones?

_____

_____

Did mother smoke during pregnancy, how much, which trimester?

_____

_____

Did mother drink alcohol during pregnancy, how much, which trimester?

_____

_____

Did mother use any drugs (recreational), how much, which trimester?

_____

_____

Was this child the first pregnancy for mom? _____

How many other live births, miscarriages. or terminated pregnancies did the mother have?

_____

BIRTH

Were there complications at time of delivery? Yes ☐ No ☐ Not Sure ☐

Did water break more than 24 hours before delivery? Yes ☐ No ☐ Not Sure ☐

Prolonged labor >4 hours? Yes ☐ No ☐ Not Sure ☐

Was labor induced? Yes ☐ No ☐ Not Sure ☐

Was child breech, feet or head first? Yes ☐ No ☐ Not Sure ☐

Were forceps used? Yes ☐ No ☐ Not Sure ☐

Was suction used? Yes ☐ No ☐ Not Sure ☐

Was a Caesarian section planned? Yes ☐ No ☐ Not Sure ☐

Was there an emergency Caesarian section? Yes ☐ No ☐ Not Sure ☐

Was anesthesia used? Yes ☐ No ☐ Not Sure ☐

Were there seizures? Yes ☐ No ☐ Not Sure ☐

What was the child's birth weight?

What was the child's APGAR scores at 1 min/5 min? ____;_____

NEONATAL PERIOD AND INFANCY

Neonatal

Was oxygen required? Yes ☐ No ☐ Not Sure ☐

Was an incubator required? Yes ☐ No ☐ Not Sure ☐

Did the baby stay in neonatal ICU? Yes ☐ No ☐ Not Sure ☐

Did the baby stay in hospital after mom went home? Yes ☐ No ☐ Not Sure ☐

Was baby jaundice? Yes ☐ No ☐ Not Sure ☐

Were there breathing problems? Yes ☐ No ☐ Not Sure ☐

Did the baby need a blood transfusion? Yes ☐ No ☐ Not Sure ☐

Were there seizures? Yes ☐ No ☐ Not Sure ☐

Infancy

Did the baby require surgery? (ie. Circumcision, tongue clipping)

_____

Did the baby need to switch formula 2 or more times?

_____

Did the baby need to use non milk products?

_____

Did the baby cry day, night, inconsolable?

_____

Was baby too quiet, or too good?

_____

Stiff when held or pushed you away?

_____

Floppy or limp when held or did not want to be cuddled?

_____

Colicky? _____

Hard to care for? _____

Other _____

DEVELOPMENTAL MILESTONES: Please list month and age child did the following.

Motor Milestones and development

Roll over _____

Sit without support _____

Crawl _____

Stand holding on _____

Walk holding on _____

Walk well _____

Skip _____

Ride a tricycle _____

Ride a bicycle _____

SOCIAL MILESTONES and DEVELOPMENT

Smile in response to another person _____

Tell one person apart from another _____

Become anxious, or cry with strangers _____

Become anxious, or cry when placed in strange environment without mom

_____

Play games like patty cake, or peek a boo _____

Play with dolls or stuffed animals _____

Make up or act out stories _____

Play with or along with other children without interaction _____

Play together with other children _____

SELF HELP MILESTONES and DEVELOPMENT

Drink from a cup _____

Eat with a spoon _____

Dress with minimal to no assistance _____

Use toilet for urine _____

Use toiler for bowel movement _____

Stay dry during daytime _____

Stay dry at nighttime _____

SPEECH AND LANGUAGE MILESTONES and DEVELOPMENT

Make first sounds _____

Squeal, gurgle, coo _____

Babble, running sounds together _____

Say Mamma, dada with meaning _____

Say first words with meaning other than mama, dada _____

Say first phrase of several words _____

Become easily understood by others _____

Did Child ever: (Check)

Make strange sounds or use strange language ☐

Have speech impediment ☐

Require speech therapy ☐

Have discontinuous language therapy ☐

Have language development stop or regress ☐

Often repeat words or phrases they have just learned instead of responding to what was just said or asked ☐

Use other pronouns to refer to themselves such as " he, she, instead of I or me" ☐

Use other pronouns when referring to others ☐

Seldon or never begin conversation with someone else (once they could speak) ☐

Only talk to themselves, not others ☐

OTHER DEVELOPMENTAL CONCERNS

Has anyone ever suggested that your child might have a developmental delay? ☐

Has anyone every suggested your child might be mentally handicapped or delayed? ☐

Will they sit near you or others? ☐

Will your child look at people, talk to them, interact with them in a way you would expect them to? ☐

Has your child, or do they do any of the following:

Body rock ☐

Head bang ☐

Hand flap ☐

Toe walk ☐

Make repetitive nonsense sounds when old enough to speak normally ☐

SOCIAL HISTORY

Does your child prefer to be alone or with others? _____

Does your child have good, close friends? _____

- How often do they get together and for what activities?

  _____

What are your child's hobbies? _____

What is your child best at doing? _____

Does your child ever feel guilty for doing anything wrong?

_____

Does your child ever feel guilty even when they have done something that is not terrible?

_____

How well does your child like themselves?

_____

What do they like about themselves?

_____

Do they make any negative statements about themselves? _____

Does your child get picked on? If so, about what and how do they handle it?

_____

How does your child handle peer pressure?

_____

Who does your child confide in? _____

Which parent is your child closest to? _____

Does your child get along with any siblings?

_____

SCHOOL HISTORY

What is your child's attitude toward learning and school?

_____

What is your child's behavior in school?

_____

Has your child ever refused to go to school? Explain.

_____

What is their best subject? _____

What are their favorite subjects?_____

What are their worst subjects? _____

What are their least favorite subjects?

_____

How are your child's grades and have they changed over time?

_____

Has your child ever been tested for learning disabilities?

_____

Has your child ever had gifted education testing?

_____

Has your child skipped a grade or been held back?

_____

FAMILY SOCIAL HISTORY. Please provide details.

Any recent stresses in the family?

_____
_____
_____
_____
_____
_____

Has anyone left the family or died recently?

_____
_____
_____

Anyone recently joined the family?

_____
_____

Any recent employment changes or job losses?

_____
_____

Any major financial changes (good or bad)?

_____
_____

How many times has your family moved during your child's lifetime? How did they adapt to this?

_____
_____

Health Goals for your child. Please list.

_____
_____
_____

Priorities for your child. Please list.

_____
_____
_____

Current Diet: _____

Daily Activity/Exercise: _____

Daily Screen Time (Hrs): _____

Sleep Time/Routine (Hrs):_____

Name of Child:_____

Name of Parent/Guardian: _____

Date:_____