BROADWAY MEDICAL CLINIC

PEDIATRIC PATIENT INTAKE FORM

Today's Date ______________Child's Name____ Date of Birth______________

Name or Nickname Child likes to be called ___________________________ Gender: M / F

PARENTS INFORMATION	**PARENT**	**PARENT**
Full Name		
Date of Birth		
Address		
City/State		
Zip Code		
Home Phone		
Employer		
Occupation		
Work Phone		
Mobile Phone		
Email		
Parent's Marital Status (circle one): Married Separated Divorced Unmarried Widowed If Divorced: Who has custody? ___________________ Visitation rights? _________________________ Other Primary Caregiver or Guardian ________________________		

EMERGENCY CONTACT - RELATIVE TO PARENTS	
Name	
Relationship	
Home Phone	
Who Referred You to Our Clinic?	

SOCIAL HISTORY
Names and ages of siblings (year of birth)
Who lives in the family home?
Does your child attend daycare? Yes / No nanny full time part time Location:
Smokers around child? Include outside smokers. Yes / No father mother brother sister GF GM friend daycare
Pets in home Yes / No dog(s) cat(s) fish birds gerbils hamster other:
Guns in Home? Yes / No (Guns are kept: Unloaded Locked Ammunition Stored Separately)
Within the last 12 months we worried whether or not our food would run out before we had money to buy more Yes/No Within the past 12 months the food we bought did not last and we didn’t have money to buy more. Yes/No

PLEASE COMPLETE BOTH SIDES OF INTAKE FORM

PRENATAL AND BIRTH HISTORY	
Pregnancy: Any illnesses or complications? Yes/No	Delivery: Any Complications? Yes/No
Any smoking, alcohol or recreational drug use during pregnancy? Yes/No	Hospital:
Mother's OB Doctor and Clinic	Birth weight
	Problems at or after birth?
	Seen in Hospital by our BMC Doctors? Yes / No

PAST MEDICAL HISTORY	
Child's Previous Doctor: Have you requested records be sent to BMC? Yes / No	Immunizations up to date? Yes / No Have you given us a copy of immunization report? Yes / No
Hospitalizations (list) 1.)	Surgeries (list) 1.)
2.)	2.)
3.)	3.)
Prior Problems (list) 1.)	
2.)	
3.)	
Medication Allergy Yes / No (list) 1.)	Food Allergy Yes / No (list) 1.)
2.)	2.)
3.)	3.)

FAMILY HISTORY	
Does any member of the CHILD'S IMMEDIATE family have any of the following conditions? If so please circle and tell us who:	
PGF=dad's father, PGM=dad's mother, MGF=mom's father, MGM=mom's mother, Uncle=child's uncle, Aunt=child's aunt, S= child's sister, B = child's brother, Mom=Mother, Dad=Father	
Anesthesia Reactions	Heart Attack
Bleeding Disorders (hemophila, VonWill.)	High Blood Pressure
ADD/ADHD	High Cholesterol
Allergies	Kidney Stones
Anxiety	Osteoporosis "bone softening"
Asthma	Overweight
Autism/Aspergers	Rheumatoid Arthritis
Cancer: If yes what type	Seizures/Epilepsy
Congenital Heart Disease	Sudden Infant Death/SIDS
Coronary Artery Disease	Stroke/Cerebrovascular Accident
Depression	Sudden Cardiac Death
Diabetes	Thyroid Disease
Drug/Substance Abuse	Ureteral/Kidney Reflux
Food Allergies	Other:
HIV/AIDS	

Anything else we should know about?

Reviewed by MD:____________________________