Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

Child New Patient Intake

Name _____ Date _____ Birthdate _____
Birth weight _____ Birth place _____ Dr. delivering _____

HEALTH

Has this child ever had any of the following:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Behavioral problems
- ☐ Broken bones
- ☐ Cancer
- ☐ Complication from childhood disease
- ☐ Diabetes
- ☐ Dislocations
- ☐ Ear trouble
- ☐ Seizures
- ☐ Eye trouble
- ☐ Fainting spells
- ☐ Hay fever
- ☐ Head injury
- ☐ Hernia
- ☐ Kidney trouble
- ☐ Rheumatic fever
- ☐ Rheumatism/arthritis
- ☐ Severe headaches
- ☐ Sexually transmitted disease
- ☐ Skin condition
- ☐ Tumor
- ☐ Yellow jaundice

Has this child ever been hospitalized for any illness or operations? If yes, please list reasons and dates.

_____

_____

Do you think your child is up to date on immunizations? ☐ Yes ☐ No

Please be prepared to supply immunization records to Medical Assistant.

List Medications this child is now taking:

Drug	Dosage	Taken for what reason?

Allergies to medications: _____

PERSONAL & FAMILY HABITS

Does anyone in your family smoke? N Y
Does anyone in your family drink alcoholic beverages? N Y
Has anyone in your family now or in the past used street drugs? N Y Type_____
Are there any firearms (guns) in your home? N Y
Do you regularly use sunscreen on your child? N Y
Who does the child live with? _____

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Child New Patient Intake (back side)

FAMILY HISTORY

Condition	YES	NO	Relation to child
Cancer			
Tuberculosis			
High Blood Pressure			
Diabetes			
Hyperlipidemia/ High Cholesterol			
Asthma			
Allergies			
Sudden Death			

Condition	YES	NO	Relation to child
Kidney Stones			
Epilepsy			
Mental/Nervous Disorder			
Heart Disease			
Genetic Disorders			
Developmental Delay			
Autism			
Other: _____			