VALLE VERDE PEDIATRICS
FOR HAPPY AND HEALTHY CHILDREN

New Patient Intake/Questionnaire:

Patient's Full Name_____ Date of Birth:_____ Child's sex _____
Address_____ Primary Phone #_____
City_____State_____ Zip Code_____ Email Address_____

Mother's Full Name_____Date of Birth_____SSN#_____
Father's Full Name_____Date of Birth_____SSN#_____

Primary Insurance_____ ID#_____Group#_____
Secondary Insurance_____ ID#_____Group#_____

Pregnancy and Birth History

Mother's age at birth:	Father's age at birth:
Any complications during pregnancy or birth?	Length of hospital stay:

Newborn History

Birth Weight:	Birth length:	Head Circumference:
Delivery Type:	Hospital, City, State	Formula or Breastmilk (circle one)

Medical History

Where has child gone for check-ups previously:	Date of last medical checkup:	Date of last dental check-up:
Is your child up-to-date on immunizations? Please supply immunization records.	Hospitalizations or surgeries:	Significant illnesses:
Female Patients: Age periods started _____	Any recent lab tests:	Imaging Tests:

Has your child had any of the following (indicate date)		
☐ Chicken pox	☐ Mumps	☐ Bed wetting (>5 years old)
☐ Vision Problems	☐ Allergies	☐ Pneumonia
☐ Asthma	☐ Kidney or bladder infection	☐ Frequent throat infections
☐ Measles	☐ Broken bones	☐ Diabetes
☐ Heart murmur	☐ Frequent ear infections	☐ Seizures
☐ Headaches	☐ Breathing trouble	☐ Anemia
☐ Eczema	☐ Sickle Cell Disease/Trait	☐ Abdominal Pain
☐ TB	☐ Fevers	☐ Other_____

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Please list any current medications:

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Have any of the child's close relatives had the following conditions:

Condition	Relative		Condition	Relative
☐ Diabetes			☐ Kidney problems	
☐ Cancer			☐ Heart disease	
☐ Seizures			☐ Skin problems	
☐ Allergies/asthma			☐ Anemia	
☐ Bleeding problems			☐ Congenital Defects	
☐ High blood pressure			☐ Chemical dependency	
☐ Mental illness			☐ Other:	

Social/Cultural History

School Name and Grade Level:	Primary Caretaker at home:
Language(s) Spoken at home:	# of family members living in the household:

Confidential Channel Communication Request

I consent to the use of the following confidential channels for the communication of information related to:
Child's Name_____

[ ] Phone [ ] Ok to Leave Voicemails
[ ] Mail [ ] Email (address) _____

Parent/Guardian Signature:_____ Date:_____

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