Hudson Valley Primary Care - Patient Intake Form- Pediatric (<19 years)

Please fill out the following information regarding your child. We enter this information in our new electronic medical record system. If you are unsure of a question, or do not feel well enough to complete this form you may ask for assistance from the medical assistant when you are called back. Thank you.

Name:__ _____ _____ _____ D.O.B. _____

Provider your child is seeing today: ☐ Dr. Foster ☐ Dr. Rubinstein ☐ Amy Kelly, N.P. ☐

Medications ☐ No ☐ Yes

If yes, please list medication and dosage: **Ex:** _____ Aspirin _ 81mg __1 tablet daily

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Allergies ☐ No ☐ Yes

Please list drug allergy(s) and reaction(s): **Ex:** _____ Penicillin Rash

_____ _____ _____ _____ _____ _____ _____ _____

Chronic Illness ☐ No ☐ Yes,

If yes, please list any chronic illnesses: Ex: Diabetes, Asthma

_____ _____ _____ _____ _____

Past Medical History Please check all that apply:

☐None ☐ADD/ADHD ☐ Allergies (seasonal) ☐ Asthma ☐ Cancer (type: _____) ☐ Depression

☐ Diabetes ☐Gallbladder Disease ☐GERD ☐Learning Disability ☐Migraines ☐Peptic Ulcer Disease

☐Seizure Disorder ☐Thyroid Disease

☐Other (please specify):_____

Past Surgical History Please check all that apply:

☐None ☐Appendectomy ☐Gastric Bypass ☐Gall Bladder Removal ☐Hernia Repair ☐Knee Scope

☐LASIK ☐Tonsil Removal

☐Other (please specify):_____

Family History Please check all that apply: ☐ None ☐ **Adopted**

	Family Member:		Family Member:		Family Member:
☐ ADD/ADHD	_____	☐ Depression	_____	☐ Mental Illness	_____
☐ Alcoholism	_____	☐ Diabetes	_____	☐ Migraines	_____
☐ Alzheimer's	_____	☐ Eczema	_____	☐ Obesity	_____
☐ Arthritis	_____	☐ High Cholesterol	_____	☐ Osteoporosis	_____
☐ Asthma	_____	☐ High Blood Pressure	_____	☐ Kidney Disease	_____
☐ Coronary Artery Disease	_____	☐ Irritable Bowel Disease	_____	☐ Seizure Disorder	_____
☐ Cancer (type:_____)	_____	☐ Learning Disability	_____	☐ Stroke	_____

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Social History

Parent Relationship: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Other
Could the patient be exposed to any occupational hazards from your place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, please list: _____

_____

If patient is of working age, are there any occupational hazards at their place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, please list: _____

_____

Are there smokers in the patient's home? ☐ No ☐ Yes
Does the patient use tobacco products? ☐ No ☐ Yes: Type:_____ Amt per Day:_____Number of years:____

_____

Primary Residence of Patient: _____
Child Care? ☐ No ☐ Yes: How many hours per week? _____
Language spoken at home? _____
Patient's School Name: _____
Patient's grade in school: _____

Immunizations

	Date:		Date:
☐ DTaP (Diphtheria, Tetanus, Pertusis)	_____	☐Meningococcal	_____
☐Hepatitis A	_____	☐MMR (Measles, Mumps, Rubella)	_____
☐Hepatitis B	_____	☐Pneumococcal	_____
☐Hib (Haemophilus Influenzae Type B)	_____	☐IPV/OPV (Polio)	_____
☐Influenza	_____	☐Varicella	_____

Medical Record Use Only: Abstracted by _____