

GREEN MOUNTAIN MEDICINE • DR. MIKA TSONGAS

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PEDIATRIC INTAKE FORM (Birth to 5 years old)

Patient's name _____ Date of first visit _____

Age _____ Date of birth _____ Gender: female ____ male ____

Mother's name _____ Father's name _____

Other parenting partner(s) _____

Physical Address _____ City _____ State _____ Zip code _____

Mailing Address _____ City _____ State _____ Zip code _____

Home/cell phone _____ Parent's work _____ Email _____

How did you hear about this clinic? _____

Reason for referral or presenting problems _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____			

Please list any known allergies to medicines, food or environmental substances: _____

Current supplements: _____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. number _____
_____ Measles _____ Pneumonia _____ Ear infections, no. _____
_____ Mumps _____ Frequent colds _____ other (please list) _____
_____ Rubella _____ Rheumatic fever

Has your child had any of the following tests? When Where Results

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech/Language _____

Injuries/Surgeries/Hospitalizations (please list): _____

PLEASE COMPLETE BOTH SIDES OF EACH PAGE

IMMUNIZATIONS

___ Measles ___ Polio ___ MMR ___ Smallpox ___ Diphtheria
___ Mumps ___ DPT ___ Tetanus ___ Influenza

Others (list) _____

Any adverse reactions to vaccines? Y N Please specify: _____

FAMILY HISTORY

___ Heart disease ___ Diabetes ___ Birth defects
___ Hypertension ___ Arthritis ___ Tuberculosis
___ Cancer ___ Allergies ___ Mental illness

PRENATAL HISTORY

Please specify any previous pregnancies by natural mother, any miscarriages or other complications with pregnancy:

Mother's age at child's birth? _____

Mother's health during pregnancy:

___ Bleeding ___ Physical or emotional trauma ___ Illnesses
___ Nausea ___ Cigarettes, alcohol, drug use ___ Medications
___ Hypertension ___ Thyroid problems ___ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

___ Birth defects ___ Birth injuries ___ Blue baby
___ Cerebral palsy ___ Seizures ___ Jaundice
___ Colic ___ Fever ___ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast-fed? _____ how long? _____ Formula? ___ milk/soy/other _____

Age began solids _____ which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** for current and **P** for past symptoms)

___ Hives ___ Burning of urine ___ Bloody urine
___ Eczema ___ Frequent urination ___ Cries easily
___ Bleeding gums ___ Heart murmur ___ Nervous
___ Nosebleeds ___ Vomiting spells ___ Sleep problems

- | | | |
|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Sensitive to light |
| <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Body/breath odor |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Motion/car sickness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Gas | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss |

Other symptoms or chronic conditions: _____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____