



PECAN TREE PEDIATRICS
Phone: (972) 772-3100 Fax: (214) 520-7120
Pediatric Health History Intake Form

Date: _____ [] Initial Visit [] Update of Information

Patient's Name: _____

Mother's Name: _____ Age: _____ Health Problems: _____

Father's Name: _____ Age: _____ Health Problems: _____

Sibling: _____ DOB: ____/____/____ [] Male [] Female Health Problems: _____

Sibling: _____ DOB: ____/____/____ [] Male [] Female Health Problems: _____

Sibling: _____ DOB: ____/____/____ [] Male [] Female Health Problems: _____

Sibling: _____ DOB: ____/____/____ [] Male [] Female Health Problems: _____

Birth Weight: _____ Gestation Age of Delivery: [] Early <38 wks [] Term 38-42 wks [] Late > 42 wks

Prenatal/Delivery Complications: [] none

List all medical problems, serious illness, injury, hospitalizations and/or surgeries below: _____ Date of diagnosis, hospitalization, or surgery

Blank lines for listing medical problems and dates.

Table with 4 columns: Medications, Name, Dosage, Frequency. Includes blank rows for entry.

List any known drug allergies/reactions: _____

List any known food or other allergies/reaction: _____ Are Immunizations up to date? [] Yes [] No

FAMILY HISTORY (Do any relatives have the following, please indicate who using D=dad, M=mom, MGM=mom's mom, MGF=mom's dad, PGM=dad's mom, PGF=dad's dad, B=brother, S=sister, MA=mom's sister, MU=mom's brother, PA=dad's sister, PU=dad's brother)

Table for Family History with columns: Condition, Relative, Condition, Relative. Lists various medical conditions.

Have there been any deaths in the family prior to age 50? [] No [] Yes: Please list relationship and reason:

Pets: [] No [] Yes: _____ [] Daycare [] School, Grade: _____ Exposure to smokers: [] No [] Yes: _____

List everyone that lives with patient: _____

Parents: [] Married [] Divorced [] Separated [] Together, but not married [] Other:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Signature of Parent: _____ Date: _____