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Pediatric New Patient Intake Form

Patient Information

Child's Name: _____

Date of Birth: ___ / ___ / _____ Age: _____ Sex: ☐M ☐F ☐Other

Parent/Guardian Name(s): _____

Preferred Contact: ☐Phone ☐Text ☐Email

Primary Care Provider: _____ Phone: _____

Referring Provider: _____ Phone: _____

Reason for Visit (check all that apply)

☐Allergic Rhinitis (sneezing, runny nose, congestion)

☐Asthma / Breathing problems

☐Food Allergy or Food Reactions

☐Eczema / Atopic Dermatitis

☐Hives / Swelling

☐Recurrent Infections

☐Other: _____

Main concern: _____

Birth & Early Childhood History

Birth: ☐Full-term ☐Premature (____ weeks)

Birth weight: _____ lbs _____ oz

NICU stay: ☐No ☐Yes (reason: _____)

Feeding history: ☐Breastfed ☐Formula-fed- Name- ☐Both

Growth/Development: ☐Normal ☐Concerns (explain): _____

Allergic Rhinitis / Nasal & Eye Symptoms

☐Sneezing ☐Runny nose ☐Congestion ☐Post-nasal drip ☐Itchy/watery eyes

Worst season: ☐Spring ☐Summer ☐Fall ☐Winter ☐Year-round

Triggers: ☐Pollen ☐Dust ☐Animals ☐Mold ☐Weather ☐Other

Prior treatments: _____

Response: ☐Yes ☐No

Asthma / Breathing Symptoms

☐Cough ☐Wheezing ☐Chest tightness ☐Shortness of breath

Frequency: ☐Daily ☐Weekly ☐Rare

Nighttime symptoms: ☐Never ☐Sometimes ☐Often

ER/hospital visits past year: _____

Steroid use past year: _____

Current inhalers/medications: _____

Food Allergy

Foods causing symptoms: _____

Reactions: ☐Hives ☐Swelling ☐Cough/Wheezing ☐Vomiting ☐Diarrhea ☐Anaphylaxis

Time from eating to reaction: ☐Minutes ☐Hours

ER visits: ☐No ☐Yes (details: _____)

Carry Epinephrine: ☐No ☐Yes

Eczema / Atopic Dermatitis

☐Itchy rash ☐Dry skin ☐Thickened patches

Age of onset: _____

Locations: ☐Face ☐Arms ☐Legs ☐Hands ☐Other

Triggers: ☐Soaps ☐Detergents ☐Foods ☐Weather ☐Stress ☐Other

Treatments tried: _____

Control: ☐Good ☐Fair ☐Poor

Hives / Swelling (Urticaria / Angioedema)

☐Hives (itchy welts) ☐Swelling of lips/eyes/hands/feet

Frequency: ☐Daily ☐Weekly ☐Monthly ☐Rare

Duration: ☐<24 hrs ☐>24 hrs

Triggers: ☐Foods ☐Medications ☐Infections ☐Pressure/Heat/Cold ☐Unknown

Treatments tried: _____

Response: ☐Yes ☐No

Past Medical History

☐Asthma ☐Allergic Rhinitis ☐Eczema ☐Food Allergy ☐Hives/Swelling

☐Recurrent Sinus Infections ☐Pneumonia ☐Ear Infections ☐Immune Deficiency

☐Autoimmune Disease ☐Other: _____

Surgical History

☐Tonsillectomy ☐Adenoidectomy ☐Ear tubes ☐Sinus Surgery ☐Other: _____

Medications

List prescriptions, inhalers, nasal sprays, OTC meds, supplements:

Allergies

☐No Known Allergies

☐Yes → List: _____

Immunization History

Vaccinations: ☐Up to date ☐Not up to date ☐Unsure

Last Flu Shot: _____

COVID-19 Vaccine: ☐Yes ☐No

Family History

Asthma: ☐Yes ☐No (Who?)

Allergic Rhinitis: ☐Yes ☐No (Who?)

Eczema: ☐Yes ☐No (Who?)

Food Allergy: ☐Yes ☐No (Who?)

Hives/Swelling: ☐Yes ☐No (Who?)

Autoimmune Disease: ☐Yes ☐No (Who?)

Social & Environmental History:

Lives with: ☐Parents ☐Siblings ☐Other: _____

Pets: ☐Cat ☐Dog ☐Bird ☐Other

Home: ☐House ☐Apartment

Place of living: City Suburb Country

Bedroom flooring: ☐Carpet ☐Hardwood ☐Tile

HEPA/air filters: ☐Yes ☐No

Tobacco exposure: ☐None ☐Yes (who smokes? _____)

Mold/water damage: ☐Yes ☐No

Age of mattress: Allergy protective covers on Mattress- Yes No

Cockroach/Rodent exposure- Yes No.

Consent & Acknowledgment

I consent to release of information for insurance and billing purposes.

I acknowledge receipt of HIPAA privacy policies.

Parent/Guardian Signature: _____ Date: ___ / ___ / _____