Evergreen Pediatric Clinic **** INTAKE AND HISTORY FORM ****

Patient's Full Na	ame:						_
	e:			n:			_
Sex assigned at	birth: \square Female \square Male						
-	/ (optional): ☐ Girl/Woman						
Pronouns (option	onal): □ She/Her/Hers □He/	'Him/His □The	ey/Them/The	eirs □: (self-deso	cribe):	
Parent/Cuardia		Polotica	اما - ،		000		
	in Name:						
Pronouns (opin	onal): □ She/Her/Hers □He/	HIM/HIS LITTE	ey/ i nem/ i ne	eirs ∟∷ (:	seir-aesi	cribe):	
Parent/Guardia	n Name:	Relation	nship:		Occi	upation:	
	onal): She/Her/Hers He/						
	•		,.				
Biological parer	nt's relationship status:	Married [Divorced	Unma	ırried	Widowed	Partnered
_							
Siblings:	Name/Gender		Date of Bi	rth		_	
			1				
	.		•			4	
	NMENT (please circle ans	-					
	adults live in the patient's						
-	rimary source of drinking						
	ns in home? <i>Yes/No</i> If y	· ·	stored lock	ked and	d unloa	ided? <i>Yes / N</i>	lo
	detectors in the home?						
	rs among caregivers? Yes		COSSAIT /A	·=:	/ D.A.C.T.		
Patient	s over 13 years - Smoking	Status: CC	JKKENI / N	IEVEK /	' PAS I		
MEDICATIONS:							
	thing he/she is currently	taking	ALLERG	GIES:			
(Including vitamins, supplements, over the Please list any allergies to the following:				lowing:			
counter and pre	escribed medications)			Г			T
					Name		Type of reaction
Medication na	me/dose				Name		Teaction
			Medicatio	on			
			Food				
			•				
			Insects				
			Environm	ental			

PATIENT'S PAST MEDICAL/SURGICAL HISTORY ** Please mark conditions diagnosed by a medical provider ** Medical History

ADD/ADHD	Yes	No
Allergies (seasonal)	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Cancer/Oncology	Yes	No
Diabetes mellitus	Yes	No
Eating disorder	Yes	No
Eczema	Yes	No

Headaches	Yes	No
Hearing loss	Yes	No
Heart murmur	Yes	No
Immune deficiency	Yes	No
Inflammatory bowel disease	Yes	No
Jaundice	Yes	No
Meningitis	Yes	No
Otitis media	Yes	No
Pneumonia	Yes	No

Scoliosis	Yes	No
Seizures	Yes	No
Sickle cell anemia	Yes	No
Strep throat (recurrent)	Yes	No
Thyroid disease	Yes	No
Tuberculosis	Yes	No
UTI	Yes	No
Varicella	Yes	No
Vision problems	Yes	No

Surgical History

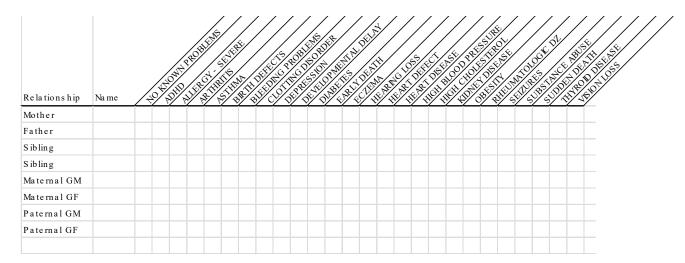
Adenoidectomy	Yes	No
Appendectomy	Yes	No
Circumcision	Yes	No
Cleft lip	Yes	No
Cleft palate	Yes	No
Cosmetic surgery	Yes	No

Fracture/surgery	Yes	No
Heart surgery	Yes	No
Hernia repair	Yes	No
Inguinal hernia	Yes	No

Lymph node biopsy	Yes	No
Tonsillectomy	Yes	No
Ear tubes	Yes	No
Umbilical hernia	Yes	No
Undescended Testicle surgery	Yes	No

Please list any other past medical history that is not included above:

FAMILY MEDICAL HISTORY: Please put a checkmark if applicable



Please list any additional history/details not included above:

***PLEASE REMEMBER TO BRING IMMUN	IZATION RECORD TO ALL APPOINTMENTS*
Signature of person who completed form:_	
Relationship to patient:	Date: