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

Patient's Full Name: _____

Preferred Name: _____ Date of birth:_____

Sex assigned at birth: ☐ Female ☐ Male

Gender Identity (optional): ☐ Girl/Woman ☐ Boy/Man ☐ Non-Binary ☐ (self-describe): _____

Pronouns (optional): ☐ She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐: (self-describe): _____

FAMILY MEMBERS:

Parent/Guardian Name: _____Relationship: _____Occupation:_____

Pronouns (optional): ☐ She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐: (self-describe): _____

Parent/Guardian Name: _____Relationship: _____Occupation:_____

Pronouns (optional): ☐ She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐: (self-describe): _____

Biological parent's relationship status: *Married* *Divorced* *Unmarried* *Widowed* *Partnered*

Siblings:

Name/Gender	Date of Birth

HOME ENVIRONMENT (please circle answers):

Which adults live in the patient's home(s)?:_____

Is the primary source of drinking water fluoridated? *Yes / No*

Firearms in home? *Yes/No* If yes, are they stored locked and unloaded? *Yes / No*

Smoke detectors in the home? *Yes / No*

Smokers among caregivers? *Yes / No*

Patients over 13 years - Smoking Status: *CURRENT / NEVER / PAST*

MEDICATIONS:

Please list everything he/she is currently taking (Including vitamins, supplements, over the counter and prescribed medications)

Medication name/dose

ALLERGIES:

Please list any allergies to the following:

	Name	Type of reaction
Medication		
Food		
Insects		
Environmental		

PLEASE TURN TO THE BACK SIDE OF INTAKE FORM TO COMPLETE→

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

Medical History

ADD/ADHD	Yes	No	Headaches	Yes	No	Scoliosis	Yes	No
Allergies (seasonal)	Yes	No	Hearing loss	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Heart murmur	Yes	No	Sickle cell anemia	Yes	No
Arthritis	Yes	No	Immune deficiency	Yes	No	Strep throat (recurrent)	Yes	No
Asthma	Yes	No	Inflammatory bowel disease	Yes	No	Thyroid disease	Yes	No
Cancer/Oncology	Yes	No	Jaundice	Yes	No	Tuberculosis	Yes	No
Diabetes mellitus	Yes	No	Meningitis	Yes	No	UTI	Yes	No
Eating disorder	Yes	No	Otitis media	Yes	No	Varicella	Yes	No
Eczema	Yes	No	Pneumonia	Yes	No	Vision problems	Yes	No

Surgical History

Adenoidectomy	Yes	No	Fracture/surgery	Yes	No	Lymph node biopsy	Yes	No
Appendectomy	Yes	No	Heart surgery	Yes	No	Tonsillectomy	Yes	No
Circumcision	Yes	No	Hernia repair	Yes	No	Ear tubes	Yes	No
Cleft lip	Yes	No	Inguinal hernia	Yes	No	Umbilical hernia	Yes	No
Cleft palate	Yes	No				Undescended Testicle surgery	Yes	No
Cosmetic surgery	Yes	No						

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

FAMILY MEDICAL HISTORY: Please put a checkmark if applicable

Relationship	Name	NO KNOWN PROBLEMS	ADHD	ALLERGY - SEVERE	ARTHRITIS	ASTHMA	BIRTH DEFECTS	BLEEDING PROBLEMS	CLOTTING DISORDER	DEPRESSION	DEVELOPMENTAL DELAY	DIABETES	EARLY DEATH	ECZEMA	HEARING LOSS	HEART DEFECT	HEART DISEASE	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	KIDNEY DISEASE	OBESITY	RHEUMATOLOGIC DZ	SEIZURES	SUBSTANCE ABUSE	SUDDEN DEATH	THYROID DISEASE	VISION LOSS
Mother																											
Father																											
Sibling																											
Sibling																											
Maternal GM																											
Maternal GF																											
Paternal GM																											
Paternal GF																											

Please list any additional history/details not included above:

*****PLEASE REMEMBER TO BRING IMMUNIZATION RECORD TO ALL APPOINTMENTS****

Signature of person who completed form:_____

Relationship to patient: _____ Date: _____