Desert Wellness Center
Family Medicine Using Modern Science and Ancient Wisdom

Pediatric New Patient Intake

Name: ________________________________ Sex: M F Date of Birth:__________ Today's Date:________

Mother's Name: ________________________________ Father's Name: ________________________________

Are both parents actively involved in child's life: Y N

Pediatrician: ______________________________________ Phone: _______________________________________

Address: ____

List of Complaints (in order of importance):

1. ____
2. ____
3. ____
4. ____

Allergies to Medications/Food:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

Current Medications and Supplements (include dosage): ____

____

____

Previous Surgeries and Hospitalizations, include date: ____

____

____

Please list date of your child's last:

Doctor's visit: ___________________ Blood Work:____________________ Dental Exam:___________________

Eye Exam: ____________________ Other Imaging:_________________

Pregnancy History:

Previous preg. (#) ________ Previous Birth (#): _________

Mother's age at time of conception: ____________ Father's age at time of conception: ______________

Prenatal care: Y N OB/midwife: ____

Please circle all that apply.

Nausea/vomiting Anemia Gestational diabetes Bleeding Infection

High Blood pressure Preeclampsia Thyroid condition Physical Trauma Emotional Stress

Coffee Smoking Alcohol Recreational Drugs

Prescription medication (please list): ____

Desert Wellness Center
Family Medicine Using Modern Science and Ancient Wisdom

Birth History:

Did baby deliver on time? Y N If No, + weeks = ______ or - weeks = ______

Length of labor: ___________ Vaginal birth: Y N

Child's Health at birth: ___________ Birth weight: _____________ Birth Length: ______________

Were there any birth complications? ____

Hearing tested? Y N Passed? Y N

Child's Medical History:

Breast Fed: Y N For how long: ___________ Age when formula introduced: ______________

Type of formula: ________________ When was solid food introduction? ____________________________

When did the following milestones occur:

Rolling over: __________ Sitting: __________ Teeth:__________ Walking: __________ Talking: __________

Speech difficulty? Y N Learning Difficulty: Y N

How many times has the child taken antibiotics? _________________

Vaccination history:

Please indicate if Yes (Y), No (N), or had Some (S):

Hepatitis B: Y N S Rotavirus: Y N S DTaP: Y N S Hemophilis (Hib): Y N S

Pneumoccoal (PCV): Y N S Chicken Pox: Y N S MMR: Y N S Polio: Y N S

Hepatitis A: Y N S HPV: Y N S Meningococcal: Y N S Tdap: Y N S

Other:_____________________

Family History

Disease	Mother	Father	Siblings	Maternal grandparents	Paternal grandparents
Alcoholism/Addiction					
Allergies					
Anemia/clotting disorder					
Anxiety disorder					
Arthritis					
Asthma					
Autism					
Autoimmune disease					
Birth defect					
Cancer (include type)					
Depression/Bipolar					
Developmental delay					
Diabetes					

Epilepsy/seizures					
Heart Attack/Stroke					
High cholesterol					
High Blood Pressure					
Hypoglycemia					
Immune Dysfunction					
Kidney Disease					
Liver Disease					
Migraines					
Thyroid Disease					
Other:					
Other:					

Social History:

Please indicate Yes (Y), No (N), or Past (P) – only if pertinent:

Antacids: Y N P Smoking: Y N P Packs per day & number of years ___________________________

Analgesics: Y N P Coffee: Y N P Cups per day if yes or past_________________________________

Laxatives Y N P Alcohol Y N P Amount if yes or past_____________________________________

Steroids Y N P Soda Y N P Amount if yes or past ____________________________________

Recreational Drugs Y N P

Addictions and/or treatment for addictions: Y N P Explain: _________________________________

Exercise: How often: __________________ Type: _____________________________

Sleep: Amount: _____________ Wake Refreshed?__________ Trouble Falling or Staying Asleep?__________

History of Mental/Physical/emotional Abuse? ____

School: __________________________________ Enjoy school: ___________________________________

Hobbies: ____

Diet:

Please describe your typical meals:

Breakfast	Lunch	Dinner

Snacks:________________________________ Beverages:____

2141 E. Warner Road
Tempe, AZ 85284

Phone: (480) 361-5188
Fax: (480) 304-3208

www.DesertWellnessCenter.com
info@DesertWellnessCenter.com

Desert Wellness Center
Family Medicine Using Modern Science and Ancient Wisdom

Review of Systems

Circle Yes (Y), No (N) or Past (P):

Skin:

Rash: Y N P	Eczema: Y N P	Color Change: Y N P
Hives: Y N P	Cancer: Y N P	Abnormal Mole: Y N P
Psoriasis: Y N P	Warts: Y N P	Dry/ Itchy: Y N P

Head:

Migraines: Y N P	Dandruff: Y N P	Oily/dry Hair: Y N P
Headache: Y N P	Hair Loss: Y N P	Head Injury: Y N P

Nose:

Nose bleeds: Y N P	Allergies: Y N P	Frequent Colds Y N P
Polyps: Y N P	Congestion: Y N P	Problems Smelling Y N P

Eyes:

Dryness: Y N P	Cataracts: Y N P	Pain: Y N P
Itching: Y N P	Glaucoma: Y N P	Watery/Discharge: Y N P
Redness: Y N P	Styes: Y N P	Vision Problems: Y N P

Mouth/Throat/Neck:

Cavities: Y N P	Goiter: Y N P	Problems speaking: Y N P
Dentures: Y N P	Gum Disease: Y N P	Problems tasting: Y N P
Sores: Y N P	Sore throat: Y N P	Problems swallowing: Y N P
Neck Stiffness: Y N P	Swollen Glands: Y N P	

Respiratory:

Asthma: Y N P	Cough: Y N P	Shortness of Breath: Y N P
Emphysema: Y N P	TB: Y N P	Wheezing: Y N P
Pneumonia: Y N P	Bronchitis: Y N P	Pain with Breathing: Y N P

Cardiovascular:

Palpitations: Y N P	Heart Attack: Y N P	High Blood Pressure: Y N P
Chest Pain: Y N P	Rheumatic Fever: Y N P	Arrhythmias: Y N P
Murmurs: Y N P	Edema: Y N P	Low Blood Pressure: Y N P

Desert Wellness Center

Family Medicine Using Modern Science and Ancient Wisdom

Urinary Tract:

Incontinence: Y N P	Kidney Stones: Y N P	Frequent Infections: Y N P
Urgency: Y N P	Blood in Urine: Y N P	Pain with Urination: Y N P

Gastrointestinal:

Heartburn: Y N P	Vomiting: Y N P	Change in Appetite: Y N P
Indigestion: Y N P	Ulcers: Y N P	Gall Bladder Disease: Y N P
Gas/Bloating: Y N P	Hemorrhoids: Y N P	Pancreatitis: Y N P
Constipation: Y N P	Liver Disease: Y N P	Stomach Pain: Y N P
Diarrhea: Y N P	Nausea: Y N P	Bowel Movements: #____/day week

Male Genitalia:

STD's Y N P	Hernia: Y N P	Erectile Dysfunction: Y N P
Discharge: Y N P	Prostate disease: Y N P	Testicular Pain/swelling: Y N P
Pain: Y N P	Sexually Active: Y N P	Frequent Night urination: Y N P

Female Genitalia:

Age of First Menses: ___________ First Day of Last Menses: __________ Length of Menses: ________

Age of Menopause: ___________ Birth control previously or currently used: _________________________

Times Pregnant: __________ Children: _________ Miscarriages: _________ Abortions: ___________

Abnormal Paps: Y N P	Discharge: Y N P	Pain with intercourse: Y N P
PMS: Y N P	Odor: Y N P	Healthy Libido: Y N P
STD: Y N P	Heavy Bleeding: Y N P	Sexually Active: Y N P
Vaginitis: Y N P	Vaginal Dryness: Y N P	Menstrual Cramping: Y N P

Musculoskeletal:

Weakness: Y N P	Tremors: Y N P	Leg Cramps: Y N P
Stiffness: Y N P	Arthritis: Y N P	Pain: Y N P

Nervous:

Paralysis: Y N P	Sciatica: Y N P	Numbness/Tingling: Y N P
Seizures: Y N P	Fainting: Y N P	Carpel Tunnel: Y N P

Mental/Emotional:

Depression: Y N P	Suicidal: Y N P	Psych Hospitalization: Y N P
Anxiety: Y N P	Fear/Panic: Y N P	Bipolar: Y N P
Eating Disorder: Y N P	Irritability: Y N P	Obsessive: Y N P