PEDIATRIC/ADOLESCENT MEDICAL INTAKE FORM

PERSONAL INFORMATION:

Patient's Name: ____
Date: ____________________

Age: __________ Date of Birth: ____________________

Gender: Female ______ Male _______

Mother's Name: ____

Father's Name: ____

Address: Street __________________________________ City___________________________

State _____________________________ Zip ____________________

Home Phone: ( )___________________________ Cell Phone: ( )________________________

Work Phone: ( ) _____________________________ Fax Number: ( )_____________________

E-Mail ____

Parent(s) Occupation(s):

____
____

In case of emergency, contact: _________________________Relationship:_________________
Home Phone: ( )__________________________ Work Phone: ( )________________________

How did you hear about us: ____

Reason for visit: ____

PRESENT HEALTH CONCERNS: Please list concerns in their order of significance.

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

MEDICATIONS:

	Current	Past		Current	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Ibuprofen	_____	_____	Decongestants	_____	_____

Please list other **previous** medications taken:

____

____

Please list all medications, supplements, and homeopathic remedies your child is currently taking, with dosages:

1.________________________2.________________________3.__________________________

4.________________________5.________________________6.__________________________

ALLERGIES:

Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medication: ____
2. Environment: ____
3. Food: ____

MEDICAL HISTORY:

________ Chicken pox   _______ Bronchitis   Tonsillitis, approx. no. ______

________ Measles   _______ Asthma   Ear Infections, approx. no. ______

________ Mumps   _______ Pneumonia   Other (please list) _____________

________ Frequent colds   _______ Thrush   ____________________________

Injuries/ Surgeries / Hospitalizations (please list):

____

____

IMMUNIZATIONS

____ Measles ____ Polio ____ MMR ____ Smallpox ____ Diphtheria

____ Mumps ____ DPT ____ Tetanus ____ Influenza

Others (list) ____

Any adverse reactions? Y N What?

____

____

FAMILY HISTORY:

_______ Heart disease _______ Diabetes _______ Birth defects
_______ Hypertension _______ Arthritis _______ Tuberculosis
_______ Cancer _______ Allergies _______ Mental illness

PRENATAL HISTORY:

Maternal age at delivery: ____________ years
Paternal age at delivery: _____________ years
Mother's health during pregnancy?

_______ Bleeding _______ Physical or emotional trauma
_______ Nausea _______ Cigarettes, alcohol, drug consumption
_______ Illnesses _______ Medications
_______ Hypertension _______ Thyroid problems _______ Diabetes

Other complications during pregnancy:

____

____

Term: Full _______ Premature _______ Late _______ Weight at birth _______
Length of labor _______________

Complications during labor and delivery:

____

____

Medication(s) during labor and delivery:

____

____

Did your child have any of the following problems shortly after birth?

_______ Birth defects _______ Birth injuries _______ "Blue baby" syndrome
_______ Cerebral palsy _______ Seizures _______ Jaundice
_______ Colic _______ Fever _______ Rashes

Other (explain)

____

____

Medications given to child during hospital stay (if any):

____

____

Child's sleep patterns: ____

Food intolerance (if any): ____

Feeding: Breast-fed? ________ How long? _______ Formula? _______ What type? _________

Age began solid food _______ Which foods? ____

Age began: Sitting ___________ Crawling _________ Walking _________ Talking _________

CHILD/ADOLECENT SYMPTOMS: (Mark C for current, P for past symptoms)

_______ Asthma

_______Hives

_______ Eczema

_______ Bleeding gums

_______ Nose bleeds

_______ Acne

_______ High fevers

_______ Chronic rash

_______ Hearing loss

_______ Diarrhea

_______ Sore throats

_______ Headaches

_______ Frequent colds

_______ Wheezing

_______ Cough

_______ Blood in urine

_______ Burning of urine

_______ Frequent urination

_______ Heart murmur

_______ Vomiting spells

_______ Anemia

_______ Stomachaches

_______ Jaundice

_______ Easy bruising

_______ Flat feet

_______ Constipation

_______ Gas

_______ No appetite

_______ Joint pains

_______ Dizzy spells

_______ Bedwetting

_______ Sleep problems

_______ Night Sweats

_______ Nervous

_______ Obesity/Overweight

_______ Eating Disorders

_______ Behavioral Problems

_______ Body/ breath odor

_______ Motion/ car sickness

_______ Depression

_______ Nightmares

_______ Canker sores

_______ Unusual fears

_______ Excessive fatigue

_______ Hair loss

DIET:

Please describe your child's typical daily diet:

Breakfast:

____

____

Lunch:

____

____

Dinner:

____

____

Snacks:

____

____

Beverages:

____

____

How many glasses of water does child drink each day on average: ________________________

Does your child have any special dietary restrictions:

____

Additional comments:

____

____

____

____

____

____

Welcome! We look forward to working with you and your child.

Rudy V. Byron, Jr. M.D.
2405 Northwestern Avenue
Lower Level Suite 15
Racine, WI 53404
P: 262 672 6393
F: 262 672 6206

Appointment Cancellation Policy Agreement:

Patient Name:____

Please call us at (262) 672-6393 by 2:00 p.m. two days (48 hours) prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Wednesday*.** If the 48 hour prior notification is not given, we must apply a ***$75.00*** charge for the ***missed appointment***.

The Office of Dr. Byron is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Thank you.

Please sign below to consent to these terms.

X____

Dr. Rudy V. Byron
2405 Northwestern Ave
Lower Level Suite 15
Racine, WI 53404

Medical Information Release and Health Information Privacy Notice Form
(HIPAA RELEASE FORM)

Patient Name:____Date of Birth: ______________

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse: ____

[ ] Child(ren):____

[ ] Other: ____

[ ] Information is not to be released to anyone.

This notice is effective as of the date signed. This authorization will expire seven years after the date on which you last received services from the clinic.

Messages

Our office does like to confirm your reserved time prior to your appointment day. We may occasionally need to leave a voicemail message or leave a message with a family member for you to call our office. Our office also uses an online communication portal called Hello Health for secure messaging.

Please indicate your communication preference below:

Please call: [ ] My Home [ ] My Work [ ] My Cell: ______________

[ ] My E-Mail:____

If you are unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other: ____

The best time to reach me is (*day*)_____________________between (*time*) ____________

Signed:____Date:_______________________