Pediatric Infectious Diseases
Health History Intake

Appointment date: ____________ Patient name: ____

Preferred name: ___________________ Date of birth: ______________ Gender at birth: □ Male □ Female

Gender identity: □ Male □ Female □ Other: ________________________ Preferred language: ________________________

What brings you in today? ____

Please check the symptoms you have on a regular basis or right now.		**□ NONE**
□ Poor appetite	□ Weight loss or lack of weight gain	□ Cough
□ Nausea	□ Long lasting or unexplained fevers	□ Wheezing
□ Vomiting	□ Low energy or fatigue	□ Hoarse voice
□ Sore throat	□ Headaches	□ Chest pain
□ Nasal congestion	□ Lightheadedness	□ Irregular heart beat
□ Changes in growth	□ Seizures	□ High blood pressure
□ Belly pain	□ Chills or night sweats	□ Wetting or urine accidents
□ Increased thirst or urination	□ Red or painful eyes	□ Painful urination
□ Diarrhea	□ Frequent mouth sores	□ Back pain
□ Dental problems	□ Achy joints	□ Coordination problems
□ Constipation	□ Red or swollen joints	□ Bleeding or excessive bruising
□ Blood in stool	□ Hair loss	□ Irregular menstrual periods
□ Sleep problems	□ Rash	□ Anxiety or stress
□ Changes in vision	□ Enlarged lymph nodes	□ Depression or sad mood
□ Changes in hearing	□ Heat or cold intolerance	□ Dental problems
□ Other ____		

Current fever pattern □ does not apply

Frequency: _________ times per day OR every _________ days

Other symptoms with fever: □ rash □ conjunctivitis □ joint pain or swelling □ belly pain □ other

Lifetime infections □ **NONE**

	Number	Description
Ear infection	___________________	____
Blood infection	___________________	____
Lung infection	___________________	____
Urine, bladder or kidney infection	___________________	____
Brain or spinal fluid infection	___________________	____
Other ______________________	___________________	____

Known medical conditions □ **NONE**

____ ____

____ ____

Current Medications including prescriptions, supplements, vitamins, herbs □ **NONE**

Medication	Amount you take	How many times per day?
____	__________________	_________________________
____	__________________	_________________________

PLEASE FILL OUT THE BACK OF THIS FORM.

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Medication Allergies and Side Effects ☐ NONE	
Medication	Reaction
____	____

Immunizations
Up to date: ☐ Yes ☐ No, reason or reaction: ____
☐ Date of skin test for tuberculosis (TB): ____________________ ☐ Date of BCG vaccination for TB: ________________

Birth History	
Method of delivery:	☐ Vaginal ☐ Caesarean
Gestational age:	☐ Term ☐ Premature: _____________ weeks
Birth weight:	________________________
Problems during 1st year of life:	____

Social History
Who lives with the patient? ____
Who cares for the patient during the day? ____
Parents are: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other
School: _____________________________________ Grade in school: _______________
School performance: ☐ Above average ☐ Average ☐ Below Average
Activities, hobbies or sports: ____
Pets or animals at home: ☐ None ____
Other issues (stresses, divorce, custody, abuse…): ____
Travel: ☐ None ____
Outdoor activities: ☐ None ____

Family History

Relation	Age	Occupation	Medical conditions
Mother			
Father			
Sibling			
Sibling			

Past Surgeries ☐ NONE		
Surgery	Date	Hospital and Surgeon
_____________________________	____________	____

Past Hospital Stays ☐ NONE		
Reason	Dates	Hospital
_____________________________	____________	____

Is there anything else we should know about the patient or your family? ____

Phone number to call with your lab results: ______________________

Name and location of your pharmacy: ____