SANTA MONICA FAMILY PHYSICIANS
PEDIATRIC INTAKE QUESTIONNAIRE

PATIENT NAME: _____
DOB: _____

Form completed by: _____
Relation to patient: _____
Date completed: _____

Please list all those living in your child's home

Name	Relationship to Child	Age

Does anyone at home smoke? □ Yes □ No

Birth History

Birth weight: _____
Full term ____ Pre-term _____ (specify weeks)
Vaginal _____ Cesarean _____
Were there any complications during the pregnancy, at birth, or shortly after birth?
_____
Feeding: Formula ___ Breast milk ___ Both ___

Immunizations

Are your child's immunizations up to date? Please attach the most recent vaccination records. □ Yes □ No

General

Does your child have any medical conditions? If yes, please list. Please include allergies, asthma, heart problems, etc. □ Yes □ No
_____
_____
_____

Has your child been diagnosed with any behavioral disorders? If yes, please list.
□ Yes □ No
_____
_____
_____

Has your child had any surgeries or hospitalizations? If yes, please list.
□ Yes □ No
_____
_____

Does your child take any medications or vitamins? If yes, please list. □ Yes □ No
_____
_____

Does your child have any drug allergies? If yes, please list. □ Yes □ No
_____
_____

Family History

Please list any medical problems in the family. Include any cancers, psychiatric diagnoses, childhood disorders, heart disease, etc.
Mom _____
Dad _____
Sibling (1)_____
Sibling (2)_____
Other (please specify) _____
_____

Daily Living

On average, how many hours of sleep does your child get in a day? _____

What is your child's typical diet?
_____
_____

What physical activity does your child do? (Minutes/day and days/week)
_____
_____