UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0300004

PLEASE WRITE YOUR NAME AND HOSPITAL MEDICAL RECORD NUMBER (IF KNOWN)

INITIAL INTAKE—PEDIATRICS 0 YEARS – 8 YEARS

This form is written from the viewpoint of the child as patient. Your answers on this form will help us better understand you or your child's medical concerns and conditions. If you cannot remember specific details, please provide your best guess. ***Thank you!***

Completed ☐For ☐By ______________________________(Child's Name)

Language you use the most: ☐English ☐Spanish ☐Other: ______________________________

Do you have religious, spiritual or cultural beliefs or practices important to your health care decisions?

☐No ☐Yes— Please describe: ______________________________

ALLERGY LIST: Please list any allergies or problems you have with: **medicines, food, shellfish, latex (balloons, rubber), tape, etc.** and what happens to you when you take or use them. **☐NO ALLERGIES**

ALLERGY TO	REACTION/WHAT HAPPENS

MEDICATION LIST: Please list all medicines you take now. Include those without a prescription: **over-the-counter, vitamins, supplements, herbals, eye-drops, patches, etc.** **☐NO MEDICINES**

MEDICINE NAME	HOW MUCH (DOSE)	HOW OFTEN (FREQUENCY)	HOW DO YOU TAKE IT? (ROUTE)	COMMENTS

Name of your Pharmacy ______________________________ Location ______________________________

Medicine refills – Prefer ☐30 days ☐90 days

MEDICAL HISTORY

Please check any physical or mental health conditions (or problems) you have now or have ever had.
Add the year it started, if known. Please add any other conditions if not listed. ☐NONE

✓	DATE	CONDITION	✓	DATE	CONDITION	✓	DATE	CONDITION
		ADDADHD			Heart Disease			Pneumonia (in the hospital)
		Allergies			Heart murmur			Scoliosis
		Asthma			Heartburn/GERD			Serious Infections
		Cancer			Hepatitis C			(in hospital or many)
		Depression			HIV/AIDS			- Strep throat
		Developmental Delay			Hypertension (High Blood Pressure)			- Urinary Tract
		Diabetes			Inflammatory bowel disease			Sickle Cell
		Dialysis			Jaundice			Sleep Apnea
		Eczema			Lead poisoning			Stroke
		Epilepsy/seizures			Neuromuscular Dx			Vision changes
		Growth failure			Obesity			
		Headaches			Otitis Media			
		Hearing Loss			Pain all the time (Chronic)			

Have you had any serious injuries, trauma or accidents or hospital stay? Please list with the date, if known.

DATE	DESCRIPTION

How many times have you been seen in an Emergency Department in the past year? ☐None ☐1-3 ☐4-6 ☐7 or more

Do you have any concerns with growth and development, school, friends, family, etc? ☐No ☐Yes - Please describe:

SURGICAL HISTORY (AND PROCEDURES) ☐NONE

Do you have any metal or plastic implants? ☐Yes – ☐valves ☐rods ☐pins ☐shunt ☐fistula
☐pacemaker or other heart device ☐cardiac stent

Have you had an organ or tissue transplant? ☐Yes – What organ/tissue?____________________

Have you ever had – ☐abnormal EKG ☐abnormal Chest X-Ray ☐problems with anesthesia ☐blood transfustion

Please list any surgeries or procedures you have had. Add the date if you know it.

✓	DATE	CONDITION	✓	DATE	CONDITION	✓	DATE	CONDITION
		Adenoidectomy			Gastrostomy			Orthopedic -
		Appendectomy			Heart -			Tonsillectomy
		Cleft lip			Hernia - ☐Inguinal			Traumatic injury
		Cleft palate			☐Umbilical			VP Shunt
		Ear tubes			Lymph node biopsy			

FAMILY HISTORY

☐NONE

Mother's height________ Father's height________

Please list those in your family who have or have had the following:

Relationship	Name	Status Alive Yes	No	Cancer	Depression	Diabetes	Heart Attack (note age)	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Cystic fibrosos	Death from infection or unexpected before 30 years old	Diabetes before 30 years old	Heart attack before 40 years old	Problems with Anesthesia	Details
Mother																	
Father																	
Sister																	
Brother																	

Are your vaccinations up to date? ☐Yes ☐No

BIRTH HISTORY

Birth Length________ Birth Weight________ Birth Head Circ.________

Discharge Weight________ Gestational Age________ Duration of Labor________

Delivery Method: ☐Vaginal ☐C-Section ☐Other/Details: *(Model has lots more detailed choices)*

APGAR Scores: APGAR 1________ APGAR 5________ APGAR 10________

Feeding Method: ☐Breast Fed ☐Bottle Fed ☐Other:

Additional Comments

Age of mother at patient's birth (in years):________

Did the mother have any problems with the pregnancy?________

Where was the child born?________

Please read each section and match the answer to the amount of activity you are able to do –

Without stopping can you:	
walk up 3 flights of steps or walk several blocks?	☐Yes ☐No
walk up more than 1 flight of steps or 2 blocks?	☐Yes ☐No
walk up one flight of steps or less.	☐Yes ☐No
Do you get short of breath or have chest pain when lying in bed?	☐Yes ☐No

NYHA CATEGORIES

Symptoms = shortness of breath, angina

Class 1 – No symptoms and no limitation in ordinary physical activity.

Class 2 – Mild symptoms and slight limitation during ordinary activity.

Class 3 – Marked limitation in activity due to symptoms.

Class 4 – Severe limitations. Experiences symptoms even while at rest.

Why do you need to stop walking? (Check all that apply)

- ☐Not applicable
- ☐Joint / back pain
- ☐Overweight
- ☐Weak, tired, dizzy
- ☐Chest pain/pressure
- ☐Muscle cramps
- ☐Short of breath

DEVELOPMENTAL HISTORY

Write the date when first able to do the following (based on current age):

Birth-1 Month	
	Follows visually
	Appears to respond to sound
2 Months	
	Follows visually through range of 90 degrees
	Lifts head momentarily
	Social smile
4 Months	
	Gurgles, coos, babbles, or similar sounds
	Follows parents movements by turning head from one side to facing directly toward
	Follows parents movements by turning head from one side almost all the way to the other side
	Lifts head off ground when lying on back
	Lifts head to 45' off ground when lying on back
	Lifts head to 90' off ground when lying on back
	Laughs out loud without being tickled or touched
	Plays with hands by touching them together
	Will follow parent's movements by turning head all the way from one side to the other
6 Months	
	Hold head upright and steady
	When placed prone will lift chest off the ground
	Occasionally makes happy high-pitched noises (not crying)
	Rolls over form stomach to back and back to stomach
	Smiles at objects when playing alone
	Seems to focus gaze on small (coin-sized) objects
	Will pick up toy if placed within reach
	Can keep head from lagging when pulled from supine to sitting
9 Months	
	Passes small objects from one hand to the other
	Will try to find objects after they're removed from view
	At times holds two objects, one in each hand
	Can bear some weight on legs when held upright
	Picks up small objects using a 'raking or grabbing' motion with palm downward
	Can sit unsupported for 60 seconds or more
	Will feed self a cookie or cracker
	Seems to react to quiet noises
	Will stretch with arms or body to reach a toy
12 Months	
	Can walk alone or holding on to furniture
	Can play 'pat-a-cake' or wave 'bye-bye' without help
	Refers to parent by saying 'mama,' 'dada' or equivalent
	Can stand unsupported for 5 seconds
	Can stand unsupported for 30 seconds
	Can bend over to pick up an object on floor and stand up again without support

12 Months Continued	
	Can indicate wants without crying/whining (pointing, etc.)
	Can walk across a large room without falling or wobbling from side to side
	Turns to you when you say his/her name
18 Months	
	If ball is rolled toward child, child will roll it back (not hand it back)
	Can drink from a regular cup (not one with a spout) without spilling
24 Months	
	Copies parent's actions, e.g. while doing housework
	Can put one small (less than 2 inches) block on top of another without it falling
	Appropriately uses at least 3 words other than 'dada' and 'mama'
	Can take greater than 4 steps backwards without losing balance, for example, when pulling a toy
	Can take off clothes, including pants and pullover shirts
	Can walk up steps by self without holding onto the next stair
	Can point to at least 1 part of body when asked, without prompting
	Feeds with spoon or fork without spilling much
	Helps to pick up toys or carry dishes when asked
	Can kick a small ball (for example, tennis ball) forward without support
3 Years	
	Child can stack 4 small (less than 2 inches) blocks without them falling
	Speaks in 2-word sentences
	Can identify at least 2 of pictures of cat, bird, horse, dog, person
	Throws ball overhand, straight, toward parent's stomach or chest from a distance of 5 feet
	Adequately follows instructions: 'put the paper on the floor; put the paper on the chair; give the paper to me'
	Copies a drawing of a straight vertical line
	Can jump over paper placed on floor (no running jump)
	Can put on own shoes
	Can pedal a tricycle at least 10 feet
4 Years	
	Can wash and dry hands without help
	Correctly adds 's' to words to make them plural
	Can balance on 1 foot for 2 seconds or more given 3 chances
	Can copy a picture of a circle
	Can stack 8 small (less than 2 inches) blocks without them falling
	Plays games involving taking turns and following rules (hide & seek, cops & robbers, etc.)
	Can put on pants, shirt, dress, or socks without help (except help with snaps, buttons, and belts)
	Can say full name
5 Years	
	Can appropriately answer the following questions: 'What do you do when you are cold? Hungry? Tired?'
	Can fasten some buttons
	Can balance on one foot for 6 seconds given 3 chances
	Can identify the longer of 2 lines drawn on paper, and can continue to identify longer line when paper is turned 180 degrees
	Can copy a picture of a cross (+)

5 Years Continued	
	Can follow the following verbal commands without gestures: “Put this paper on the floor… under the chair…in front of you…behind you”
	Stays calm when left with a stranger, e.g. baby sitter
	Can identify objects by their colors
	Can hop on one foot 2 or more times
	Can get dressed completely without help
6-8 Years	
	Can draw a picture of a person that includes a least 3 parts, counting paired parts, for example, arms, as one had at least 6 parts on that same picture
	Can appropriately complete 2 of the following sentences: “If a horse is big, a mouse is…”; “If fire is hot, ice is…”; “If mother is a woman, dad is a…”
	Can catch a small ball (e.g. tennis ball) using only hands
	Can balance on one foot for 11 seconds or more given 3 chances
	Can copy a picture of a square
	Can appropriately complete all of the following questions: “What is a spoon made of?”; “What is a shoe made of?”; “What is a door made of?”

PERSONAL HISTORY

Do you live with ☐Father ☐Mother ☐Grandparent(s) ☐Guardian ☐Foster care ☐At a facility
☐Other ______

Are you in school or day care? ☐No ☐Yes – Grade______ ☐Home schooled ☐Homebound ☐Special Education
☐Other ______

Are you in a special program? ☐Gifted/accelerated ☐IEP ☐Other: ______

How many days of school have you missed this academic year because of illness? ☐None ☐1-5 ☐6-10 ☐>10

Does anyone at home smoke? ☐No ☐Yes - Name ______

Do you have any problems sleeping? ☐No ☐Yes – ☐nightmares ☐sleep walking ☐bedwetting ☐snoring
☐teeth grinding ☐trouble getting to sleep ☐trouble staying asleep ☐Other: ______

How much time do you spend in front of the television and/or computer each day?
☐None ☐1 hour ☐ 2-4 hours ☐>4 hours

Do you exercise regularly? ☐No ☐Yes –
How many times per week? ______
For how long? ______
What do you like to do for fun? ______

Do you use: ☐Glasses ☐Contacts ☐Hearing aids ☐False teeth ☐Cane ☐Walker ☐Wheel chair

Safety: Do you use? ☐Car seat or booster seat ☐Bike helmet

Have you traveled outside the United States within last year? Yes No If yes, where? ______

☐Completed by ______ Date ______
NAME/SIGNATURE

☐*Interpreter present* ______ ☐*Cyracom phone ID #* ______
NAME/SIGNATURE

☐Reviewed by ______ ☐Entered into EMR Date ______
NAME/SIGNATURE