Metropolitan Pediatrics, L.L.C.

Patient Intake Form

Patient Name: _____ Date of Birth: _____/_____/_____

MR#: _____ Date of Service: _____/_____/_____

❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic
❑ Native Hawaiian or Other Pacific Islander ❑ White (non-Hispanic) ❑ Other

Welcome to Metropolitan Pediatrics! Please take the time to fill out this form as accurately as possible so we can most appropriately address your child's health needs. Thank you!

Birth History – Pregnancy:

Did mother: Smoke? ❑ Yes ❑ No
Drink alcohol? ❑ Yes ❑ No
Use drugs/medications? ❑ Yes ❑ No
If yes, what kind(s)? _____
_____
Experience illness/complications? ❑ Yes ❑ No
If yes, what kind(s)? _____
_____

Birth History – Delivery/Newborn Period:

Delivery Type: ❑ Vaginal ❑ C-section
Gestational Age: _____ Birth Weight: _____
Date hepatitis B given: _____/_____/_____
Problems in newborn period: _____
_____
_____
_____
_____
_____

Patient Medical History:

❑ ADD/ADHD
❑ Allergies
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Cancer/Oncology
❑ Diabetes mellitus
❑ Eating disorder
❑ Eczema
❑ Headaches
❑ Hearing loss
❑ Heart murmur
❑ Immune deficiency
❑ Inflammatory bowel disease
❑ Jaundice
❑ Meningitis
❑ Otitis media
❑ Pneumonia
❑ Prematurity
❑ Scoliosis
❑ Seizures
❑ Sickle cell
❑ Strep throat (recurrent)
❑ Thyroid disease
❑ Tuberculosis
❑ UTI
❑ Varicella (chickenpox)
❑ Vision problems
❑ Other: _____
_____
_____

Patient Surgical History:

❑ Adenoidectomy
❑ Appendectomy
❑ Circumcision
❑ Cleft lip
❑ Cleft palate
❑ Cosmetic Surgery
❑ C-section
❑ Fracture surgery
❑ Heart surgery
❑ Hernia repair
❑ Inguinal hernia
❑ Lymph node biopsy
❑ Tonsillectomy
❑ Ear tubes
❑ Umbilical hernia
❑ Undescended testicle surgery
❑ Other: _____
_____
_____

MORE QUESTIONS ON THE BACK SIDE ⇨

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Family History

Have any family members had the following conditions? Please mark an 'X' by each condition that applies.

Family Member Name:	Date of Birth:	Lives with patient?	No Known Problems	Other	ADHD	Allergy-Severe	Arthritis	Asthma	Birth Defects	Bleeding Problem	Clotting Disorder	Depression	Developmental Delay	Diabetes	Early Death	Eczema	Hearing Loss	Heart Defect	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Obesity	Rheumatologic Disease	Seizures	Substance Abuse	Sudden Death	Thyroid Disease	Vision Loss
Mother:	/ /																											
Father:	/ /																											
Sibling:	/ /																											
Sibling:	/ /																											
Maternal Gma:																												
Maternal Gpa:																												
Paternal Gma:																												
Paternal Gpa:																												
Other:	/ /																											

List any other conditions (by family member):

_____

_____

_____

_____