Well Visit Intake Form

Name of Person Completing Form: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Concerns Today: _____

Is there anything you would like to speak to the provider about **privately**: □ No □ Yes

Patient Past Medical History

Allergies: _____

Medications/Vitamins: _____

_____

Medical Problems: _____

Surgical History: _____

Hospitalizations: □ No □ Yes: _____

Developmental problems: □ No □ Yes: _____

Therapies: □ No □ Yes, list: _____

Patient Nutrition and Physical Activity

Infant diet: □ formula □ breastmilk □ solids/baby food

Check all that apply: □ Regular diet □ Daily fruits and vegetables □ Sugary drinks □ Mostly water

□ Frequent snacking □ Room for improvement □ Mostly home cooked meals □ Tube feedings/purees

Physical activity: □ Less than 3 hours per week □ More than 3 hours per week

Patient Social History

Patient lives with: □ Biological Mother □ Biological Father □ Sibling(s) □ Step-mother □ Step-father

□ Foster Care □ Other: _____

If two separate households, the parenting time share is: _____

Do you have stable housing: □ Yes □ No

History of Abuse/ Trauma: □ No □ Yes (□ Physical □ Verbal □ Sexual □ Domestic Violence Exposure)

Guns in the home □ Yes (□ Secured □ Unsecured) □ No

Secondhand Smoke Exposure □ Yes (□ In home □ In car □ Outside) □ None

Car Safety: □ Rear Facing Car Seat □ Forward Facing Car Seat □ Booster Seat □ Seat belt □ None

For Ages 12+

(Please note that provider will likely ask to speak with teen privately)

Tobacco/Vaping Use: □ No □ Yes

Alcohol Use: □ No □ Yes

Marijuana Use: □ No □ Yes

Illicit Drug Use: □ No □ Yes

Are you sexually active: □ No □ Yes

FAMILY HISTORY

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Asthma	☐	☐		High Cholesterol	☐	☐	
Autism	☐	☐		High Blood Pressure	☐	☐	
ADHD	☐	☐		Genetic Disorder	☐	☐	
Congenital Heart Disease	☐	☐		Seizures	☐	☐	
Diabetes	☐	☐		Cancer	☐	☐	
Eczema	☐	☐		Bleeding Disorder	☐	☐	
Drug/Alcohol Abuse	☐	☐		Depression/Anxiety	☐	☐	
Heart problems	☐	☐		Other Mental Health	☐	☐	
Thyroid	☐	☐		Other	☐	☐	

ANSWER THE FOLLOWING IF NEEDING **SPORTS PHYSICAL** CLEARANCE:

Medical Questions	Yes	No
1. History of head injury or concussion?		
2. Have you ever had any broken bones or dislocated joints?		
3. Does your heart ever race or skip beats?		
4. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
5. Have you ever passed out or nearly passed out during or after exercise?		
6. Have you ever been told by a doctor that you have a heart problem such a murmur, high blood pressure, high cholesterol, Kawasaki disease, or a heart infection?		
7. Have you ever had an unexplained seizure?		
8. Has a family member died of heart problems or had an unexpected death before age 50?		
9. Is there a family history of cardiomyopathy, Marfan syndrome, long QT syndrome, Brugada syndrome, or other tachycardia syndrome?		
10. Is there a family history of unexplained fainting?		