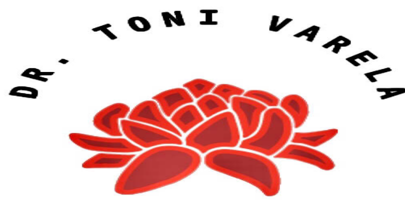

Dr. Toni Varela, NMD

939 Hartz Way, Ste 100 Danville, Ca 94526 • (925)786-0375

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Welcome to your first visit. Enclosed is a complete intake form to submit prior to your visit. You can email it to the clinic at info@drtonivarela.com beforehand or bring it with you to the office visit.

Patient's Name: ________________________________ Date: _________

Age: _______ Date of Birth: ________________ Gender: Female Male

Parent/Guardian's Name: _____________________

Address: ____

Telephone (home): ____________ (Parent's work):_______________________

Parent(s) email address:

____

Primary Care Doctor: ____

How did you hear about this clinic?________________________________

Name of doctor's office/hospital/clinic where your child's health records are kept:

____

____

Reason for referral or presenting problems:

____

____

____

MEDICATIONS

Drug	Now	Past	Drug	Now	Past
Aspirin			Anti-Histamine		
Tylenol			Other:		
Ibuprofen					
Antibiotics					

Allergies to medicines, foods, environment: ___________________________

MEDICAL HISTORY (check any that your child has or has had)

X	Condition	X	Condition	# of infections
	Chicken Pox		Tonsillitis	
	Scarlet Fever		Ear Infections	
	Measles		Strep Throat	
	Mumps		Rheumatic Fever	
	Rubella		Other:	
	Pertussis			

Has your child ever had any of the following? When, Where, and Results.

Electroencephalograms (EEG):
____

Psychological evaluations:
____

Hearing tests:
____

Speech/language tests:
____

Blood tests:
____

Please bring in any relevant laboratory and imaging results if you have access to them.

Injuries/surgeries/hospitalizations (please list):
____

____

IMMUNIZATIONS

X	Immunization	X	Immunization
	MMR		Tetanus
	DPT		Rubella
	Chicken Pox		Polio
	Measles		H. flu
	Diphtheria		Flu
	Small Pox		Other:
	Mumps		

Adverse reactions: Y N

If yes, please explain: ____

FAMILY HISTORY

X	Condition	X	Condition
	Heart Disease		Arthritis
	Hypertension		Allergies
	Cancer		Osteoporosis
	Mental Illness		Birth Defects
	Diabetes		Asthma
	Tuberculosis		Other:

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

____

____

Mother's age at child's birth: ______

Mother's health during pregnancy:

X	Condition	X	Condition
	Bleeding		Cigarettes, alcohol, drug use
	Nausea		Thyroid Issues
	Phys/emo trauma		Diabetes
	Illnesses		Medications:
	Hypertension		

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Late Length of labor: ________

Complications:____________________

Birth city & state: ______________________ Birth time: _________

Birth weight:__________

Did your child have any of the following problems shortly after birth?

X	Condition	X	Condition
	Rashes		Birth injuries
	Jaundice		Cerebral palsy
	Colic		Birth defects
	Fever		Other:
	Seizures		

Child's sleep patterns (1st year): ____

Food intolerances:

____

Breast fed: Y N How long: _____

Formula: Y N Type: (milk, soy):_____

Age began solids: _________ Which foods:__________________________

Age began:

Sitting _____ Crawling _____ Walking _____ Talking ______

SYMPTOMS

X	Condition	X	Condition	X	Condition	X	Condition
	Hives		Body/breath odor		Sore throats		Anemia
	Eczema		Night sweats		Fevers		Easy Bruising
	Chronic rash		Jaundice/ yellow skin		Cough		Tendency to bleed
	Acne		Asthma		Vomiting		Nose bleed
	Bleeding gums		Wheezing		Constipation		Joint Pain
	Hair loss		Sleep problems		Diarrhea		Flat feet
	Nervous		Nightmares		Stomach aches		Allergies
	Dizziness		Unusual fears		Frequent colds		Fatigue
	Hearing loss		Heart murmur		Bloody urine		Frequent urination
	Sensitive to light		No appetite		Burning urine		Cries easily

DIET
Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

THANK YOU. I LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY I CAN.

X____________________________________ Date: __________________

Signature