

UCSF PEHSU INTAKE FORM
*Thank you for completing this confidential form.
The physician will review the information you
have provided at your visit.*



Child's Last Name: _____ First name: _____

Date of Birth: _____ Age: _____

Parent's name: _____

Address: _____

Telephone number: _____

Date of visit: _____

Please describe the reason for your visit: _____

Birth and Medical History

Place of birth (city, state) _____

Gestational age? _____ Birth weight? _____

Problems in pregnancy? no yes (describe) _____

Problems during delivery? no yes (describe) _____

Apgar scores (if known) _____ Length of hospital stay? _____

Medical problems (please check if your child has any of the following):

- | | | |
|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> learning disability | <input type="checkbox"/> anemia |
| <input type="checkbox"/> allergies | <input type="checkbox"/> attention problems | <input type="checkbox"/> cancer |
| <input type="checkbox"/> eczema | <input type="checkbox"/> autism | <input type="checkbox"/> other: _____ |

Who is your child's regular doctor? _____

Office phone number? _____

Hospitalizations: no yes (describe) _____

Specialist visits: no yes (describe) _____

Current Medicines: no yes (list): _____

Allergies: no yes: _____

Has your child received all of the recommended vaccines? no yes
If not, please explain: _____

Does your child have any of the following symptoms (please check all that apply)?

- | | | |
|--|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> eye/vision problems | <input type="checkbox"/> sleep problems |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> skin, hair, nail problems | <input type="checkbox"/> persistent cough |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> fainting spells | <input type="checkbox"/> depression |
| <input type="checkbox"/> nervousness/anxiety | <input type="checkbox"/> breathing problems | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> urinary problems | <input type="checkbox"/> behavioral problems | <input type="checkbox"/> school problems |

For girls, what was the age at menarche (first period)? _____

Family Information

Please list all siblings names, ages and any medical problems: _____

What is your occupation? _____

Other household members occupations? _____

Does any household member work around chemicals or other strong smells? no yes
(if yes, please describe) _____

Does either parent have any medical problems? no yes
(if yes, please list) _____

Developmental history

Please recall your best estimate of:

- age (in months) at first sitting: _____
- age (in months) at first walking: _____
- age (in months) at first words: _____

Current grade level: _____

Any special education needs? no yes (describe) _____

Diet

Breast fed no yes: until what age _____
Bottle fed no yes
Does your child use any herbal or dietary supplements: no yes: _____
Do you or your child eat fish once a week or more (including canned tuna)? no yes

Home Information

Where do you live? apartment house other: _____
When was the home built? before 1978 after 1978 approximate year: _____

In your home is/are there:
 chipping paint? known lead paint?
 recent or current renovations? chemicals or substances used for hobbies?
 pesticides, repellants, or other substances used on pets, in the home, or in the garden?

Within five blocks of your home is there:
 industrial/factory site agricultural field
 waste site loud noise
 heavy traffic other _____

What is your water source? municipal well bottled water

What heat sources do you use? furnace wood stove or fireplace space heater
 other: _____

Do you have a carbon monoxide detector in your home? no yes

Do you have a smoke detector in your home? no yes

Environmental Exposure Information

Does anyone in your family or home smoke (indoors, outdoors, in the car)? no yes

Does your child work? no yes (describe) _____

If there is an exposure you are concerned about, what is it? _____

Where did the exposure occur?: home school daycare park/playground
 other: _____

Has your child been evaluated for this concern? no yes
If yes, did the evaluation include any of the following (check all that apply)?
 a visit to your regular doctor visit to a specialist
 any tests, including blood, urine, or hair testing?

