Patient Label

UT★Physicians

PEDIATRIC 0-24 MONTHS INTAKE

Patient Name: _____ DOB: _____
Language preference: ☐ English ☐ Spanish ☐ Other: _____
Does the patient have vision or hearing impairment? ☐ Yes ☐ No
Brief description of problem and reason for visit: _____
Does the patient need a Return to Daycare note? ☐ Yes ☐ No
Pharmacy: _____ Phone #: _____
Lab Preference: _____ (labs will go to Memorial Hermann unless otherwise stated)

CURRENT MEDICATIONS: Or provide a printout/list if available

Does the patient have any food or drug allergies? ☐ No ☐ Yes, please list: _____
Current Medications: Please include prescribed, over the counter, supplements, vitamins, herbs:

Name	Dosage (how much)	How often	How is it taken
1.			☐ Mouth ☐ Cream ☐ Other
2.			☐ Mouth ☐ Cream ☐ Other
3.			☐ Mouth ☐ Cream ☐ Other
4.			☐ Mouth ☐ Cream ☐ Other
5.			☐ Mouth ☐ Cream ☐ Other

Are you the patient's: ☐ mother ☐ father ☐ grandparent ☐ foster parent ☐ other: _____

Do you have a copy of the patient's immunization records today? ☐ Yes ☐ No

DIET 0-11: If child is 0-11 months, fill out this section. If child is 12-24 months, move to next section.

Breast Feeding: ☐ none average time per feeding: _____ every _____ hours _____ times/day
☐ latch firm ☐ latch intermittent ☐ comfortable ☐ slightly uncomfortable
☐ uncomfortable ☐ very uncomfortable

supplemental formula: ☐ none type: _____ Ounces each feeding: _____ times/day: _____
Supplemental Vitamin D: ☐ Yes ☐ No

Formula: ☐ none _____ ounces/feeding (average) every _____ hours or _____ times/day
☐ Similac: ☐ Enfamil: ☐ other:

Drinking Method: ☐ bottle ☐ sippy cup ☐ straw ☐ cup ☐ G-tube
☐ nasal/oral tube ☐ other:

Cereal: ☐ none ☐ less than 1 tbsp/ounce ☐ greater than 1-2 tbsp/ounce

DIET 12-24 months: If child is 12-24 months, fill out this section.

Milk Type: ☐ breast milk ☐ formula cow milk: ☐ whole ☐ 2% ☐ 1% ☐ skim
☐ almond ☐ soy ☐ other: _____
average ounces/day

Other Fluids: **Water:** ☐ none _____ cups/day average _____ ounces/day
Juice: ☐ none _____ cups/day average _____ ounces/day
Soda: ☐ none _____ cups/day average _____ ounces/day

Food:	**Breakfast**	**Lunch**	**Dinner**	**Snack**
Cereal	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐
Meats	☐	☐	☐	☐
Pasta/Rice/Breads	☐	☐	☐	☐

Special Diets: ☐ none ☐ write-in:

Dietary Supplements: ☐ multi-vitamin ☐ vitamin D ☐ iron ☐ other: _____

Calcium Source: ☐ none ☐ milk fortified drinks ☐ cheese ☐ ice cream ☐ tofu made with calcium
☐ yogurt ☐ other:

Junk Foods: ☐ none ☐ occasional ☐ # servings/day

OUTPUT:

Urine: Number of wet diapers per day:

Stool: ☐ soft stools ☐ firm stools ☐ hard stools ☐ loose stools
☐ after every feeding /day /week

SOCIAL HISTORY:					
Household Members:	☐ mother	☐ father	☐ stepmother	☐ stepfather	
	☐ foster parent(s)	☐ grandparent(s)	☐ # sister(s)	☐ # brother(s)	
Parent(s):	☐ married	☐ separated	☐ divorced	☐ unmarried	☐ parents live together
	☐ parents do not live together				
custody:	☐ mother full custody	☐ father full custody	☐ joint custody	☐ custody not established	
	☐ state custody				
Parental Work Status:	Mom: ☐ employed ☐ unemployed		Dad: ☐ employed ☐ unemployed		
	mother occupation:		father occupation:		
Child Lives:	☐ with relatives	☐ with friends	☐ shelter	☐ near freeway	☐ house
	☐ near chemical plant		☐ apartment	☐ other: _____	
Childcare:	☐ none	☐ siblings	☐ babysitter or nanny	☐ parents	
	☐ relative	☐ in child's home	☐ daycare center	☐ private home daycare	
Health Risks:	pets: ☐ inside ☐ outside	☐ household domestic violence	☐ household substance abuse		
Exposure to or Participates in:	☐ smoke or vaping or juul	☐ alcohol	☐ marijuana	☐ other drugs: _____	
	☐ visible mold	☐ cockroaches/bedbugs/lice/scabies	☐ carpet	☐ firearms	

FAMILY HISTORY: Does the patient's mother, father, sibling, grandparent, or other family members have any other following:

	Self	Mother	Father	Sibling	Grandparent	Other
Neurological problems	☐	☐	☐	☐	☐	☐
Learning problems	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Drug problems	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐
Vision problems	☐	☐	☐	☐	☐	☐
Hearing problems	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Heart problems	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Respiratory problems	☐	☐	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐	☐	☐
Stomach/Intestinal issues	☐	☐	☐	☐	☐	☐
Blood problems (anemia)	☐	☐	☐	☐	☐	☐
Genetic traits (Sickle cell, etc.)	☐	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐	☐
Disability	☐	☐	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	☐	☐
Sudden death	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

ADDITIONAL SERVICES

Home Health Services: ☐ No ☐ Yes, if yes, what company: _____

Private Duty Nursing: ☐ No ☐ Yes, if yes, what company: _____

DME/Supplies: ☐ No ☐ Yes, if yes, what company: _____ Equipment: _____

Other:

Does the patient receive therapy?	Frequency	Company
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Speech Therapy		
☐ Feeding Therapy		