DOXOLOGY HEALTH & FERTILITY

Name:
DOB:

Pediatric/Adolescent Intake

Reason for visit: _____

Previous PCP:_____ ❑ Records release signed

General Medical History

- ☐ Congenital heart disease
- ☐ Heart murmur
- ☐ Asthma
- ☐ Seasonal allergies
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Eczema/atopic dermatitis
- ☐ Frequent ear infections
- ☐ Recurrent urinary infections
- ☐ Kidney disease
- ☐ GERD/reflux
- ☐ History of Colic
- ☐ Constipation
- ☐ Diabetes/prediabetes
- ☐ Thyroid disease
- ☐ Cancer _____
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Bleeding disorder
- ☐ Migraines
- ☐ Seizures (including febrile seizures)
- ☐ ADD/ADHD
- ☐ Autism spectrum disorder
- ☐ Sensory processing issues
- ☐ Substance use/abuse
- ☐ Depression
- ☐ Attempted suicide
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Sickle cell disease or trait
- ☐ Hemoglobin C disease or trait
- ☐ Fainting during or after exercise
- ☐ Chest pain or extreme shortness of breath with exercise
- ☐ Developmental or speech delay
- ☐ Other _____ _____

Please explain any of the above marked answers or indicate anything not listed above:

_____

_____

Medical Specialist(s): _____

History of significant injuries: _____

Concerns you would like to discuss?_____

_____

_____

Menstrual History

- ☐ **N/A**

Age at first period: _____

First day of last menstrual period: _____

Cycle length _____

Duration _____

Irregular periods? _____

How often do you change your pad/tampon/cup on heavy days? _____

For how many days? _____

Which symptoms do you have *between* periods:
❑abnormal bleeding ❑cramping ❑pelvic pain ❑none

Which symptoms do you have *during* periods:
❑cramping ❑pelvic pain ❑headaches ❑mood swings ❑PMS ❑leg pain ❑back pain ❑nausea ❑vomiting ❑pain with bowel movements ❑painful urination ❑none

Have you ever been pregnant: ❑Y ❑N (please list below)

Full term _____ Preterm _____ Ectopic _____ Terminations _____ Miscarriages _____

Any pregnancy complications? ❑Gestational diabetes ❑preeclampsia ❑high blood pressure

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Surgeries/Hospitalizations/Diagnostic Tests/Procedures

Date/Year	Diagnosis/Test/Procedure	Physician	Hospital

Regular Dentist Visits: ❑within the last 6 months ❑ 6-12 months ago ❑>1 year ago ❑never
Last vision check: _____ ❑glasses ❑contact lenses ❑corrective surgery

Allergies: _____
Current Medications/Supplements and Dosages:
_____
_____

Birth History
Place of birth: _____
Type of delivery (check all that apply):
❑Vaginal ❑Vacuum ❑Forceps ❑Breech vaginal ❑VBAC
Induction? ❑ N ❑ Y (indication): _____
❑Cesarean Section (indication) _____
Delivery complications: ❑None ❑Yes: _____
Weeks' gestation at birth: _____ or ❑Term ❑Preterm
Birth weight: _____ or:
❑ Average for Gestational Age ❑ Large for Gestational Age ❑ Small for Gestational Age
NICU stay: ❑ Y ❑N If yes, why and how long? _____
Jaundice requiring phototherapy: ❑Y ❑N
Circumcision: ❑Y ❑N ❑N/A ❑ Complications: _____
Tongue or Lip Tie: ❑N ❑Y Frenotomy done: ❑N ❑Y
Newborn Metabolic Screen: ❑ Normal ❑Abnormal
❑ Further testing needed: _____
Hearing screening: ❑Passed ❑ Non-Pass: ❑Right ❑Left ❑Both ❑Retest/Referral needed
Other follow up testing recommended? ❑N/A _____
Maternal postpartum depression after delivery: ❑ Y ❑N ❑Unknown
Immunization status/preference(s):
_____ or ❑Up to date
Feeding: ❑Breastfeeding/expressed breastmilk ❑Formula feeding ❑Formula and breastmilk ❑Weaned

Family History:

- ☐ Breast cancer
- ☐ Ovarian Cancer
- ☐ Colon or other cancer_____
- ☐ Depression/Anxiety
- ☐ Other psychiatric conditions
- ☐ Migraine headaches
- ☐ Seizure disorder
- ☐ Heart disease (including unexplained sudden cardiac death) Indicate age/relationship _____
- ☐ Diabetes
- ☐ Cystic Fibrosis
- ☐ Sickle cell disease or trait
- ☐ Blood clots

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Social History
Who lives in the household?
_____
_____
_____
School/Daycare_____
Current grade _____
Academic problems? ❑Y ❑N _____
Behavioral problems? _____
Afterschool activities/Hobbies/Sports _____

How many times a week do you exercise? _____ What kind of exercise? _____
How many hours of screen time per day? _____
Do you feel safe at home? _____
Future career goals: _____
Issues with peers: ❑ N ❑ Y _____
Body image issues: ❑ N ❑ Y _____
Social media usage: ❑ N ❑ Y Self harm: ❑ N ❑ Y

Adolescent History ❑ I prefer to answer these questions in person/privately
Ok to leave confidential messages on/with ❑personal voice mail (___)_____ ❑parent ❑neither
Are you discerning religious life? ❑ N ❑Y ❑ I don't know
Faith/Spirituality: _____
Career/life goals: _____
Sexually active: ❑ N ❑Y ❑ Previously, but not now ❑Never ❑ Celibate ❑Prefer not to answer
History of sexual assault, abuse, or rape:
❑ N ❑Y ❑ I prefer to answer in person ❑Prefer not to answer
History of childhood trauma:
❑ N ❑Y ❑ I prefer to answer in person ❑Prefer not to answer
Have you ever been in the custody of somebody other than your parent(s):
❑ N ❑Y ❑ I prefer to answer in person ❑Prefer not to answer
History of sexually transmitted infections: ❑ N ❑Y _____
Interested in (check all that apply): ❑Males ❑Females ❑ N/A ❑ Prefer not to answer
Have you ever smoked/vaped/used tobacco products? ❑Y ❑N If yes, for how many years? _____
Current user? ❑ N ❑Y How often? _____
Do you drink alcohol? ❑ N ❑Y
How many times a week do you drink alcohol? _____ How many drinks at a time? _____
Do you use drugs (including Marijuana/THC)? ❑N ❑Y
What have you used? _____ Last used _____
Over the *<u>past two weeks</u>*, have you been bothered by the following:
Little interest or pleasure in doing things? ❑N ❑Y
Feeling down, depressed, or hopeless? ❑N ❑Y
Thoughts or suicide: ❑N ❑Y _____
Safety plan: ❑N/A ❑N ❑Y _____