

WAYNE STATE
UNIVERSITY
PHYSICIAN GROUP

Pediatric Intake
Newborn - 5Years

Weight_____

Height_____

B/P ____/____

Pulse_____

Resp._____

Head Circ._____

Standard-Metric

Patient Name_____ Birth Date____/____/____

Parent/ Guardian Name:_____

Contact Phone # _____

Allergies: None

Latex Iodine IV Dye Penicillin Sulfa Eggs _____

Medication List: *(example: Lipitor 20mg 1 x day)*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____

Address: _____

Phone# _____

We offer e-Prescribe for our patient's convenience.

Office Visit

AGE SPECIFIC INTERVAL HISTORY:

Nutritional Detail: *√ all that apply*

LIQUID:

Breast

Bottle Formula _____ (brand)

Milk Whole 2% _____

____ # ounces/feeding

~How Often?

Evening only

Every 2 hours

Every 3 hours

Every 4 hours

Hourly

Morning Only

On Demand

Uses a Cup for:

Milk Whole 2% _____

Juice

Water

SOLID FOOD: Age 1st given solid: ___ mos.

Baby Food

Table Food

~Food varieties given include:

Fruits

Vegetables

Breads/Cereal

Meat/Proteins

Dairy Products

Serving Size= ¼ cup for ages 1-3 years

½ cup for ages 3-5 years

Elimination: Bladder:

wet diapers/ day _____

times urinates/ day _____

Toilet Trained? **No** **Yes** _____ (age)

√ if NO Bladder Concerns

Elimination: Bowel:

stools/day _____

Toilet Trained? **No** **Yes** _____ (age)

√ if NO Bowel Concerns

Activity/ Exercise:

Exercise/ sports _____ hrs/ day

Type of exercise/

Activities _____

TV/ Computer games _____ hrs/day

Has a TV in bedroom? **Yes** **No**

IMMUNIZATIONS: Did you bring immunization records for today's visit:

YES NO

Histories

Reason for Visit: 1) _____

2) _____

When was your last **well child** visit? ____/____/____

PAST MEDICAL HISTORY

Check all that apply:

- NO Past Medical History
- ADD/ ADHD
- Abdominal Pain
- Anemia
- Asthma
- Bleeding Disorder
- Bronchitis
- Concussion
- Congenital heart disease
- Constipation
- Diabetes
- Eczema
- Fracture
- GERD (acid reflux)
- Hearing Problems
- Heart Problems / murmur
- Hypertension (↑ blood pressure)
- Menstrual problems
- Pyelonephritis
- Recurrent Earaches
- Seizure Disorder
- Urinary Tract Infection
- Vesicoureteral reflux (urine flow disorder)
- _____ other
- _____ other

PAST SURGICAL HISTORY

- NO Past Surgical History
- Appendectomy (appendix removed)
- Inguinal Hernia Repair
- Fracture w/Surgical reduction
- Dental Surgery
- Tonsillectomy (tonsils removed)
- Adenoidectomy
- PET placement (ear tubes)
- Lymph Node Biopsy/ Excision
- Umbilical Hernia Repair
- Other: _____

AGE SPECIFIC SOCIAL

Residence:

Who does pt live with? _____

Tobacco:

Smokers in pts. home? Yes No

Smokes outside only: N/A Yes No

Childcare:

Daycare: Yes _____ # days/week

Name Facility _____

Parents' Relationship: Married Divorced

Separated Living together/not married

Never Together

Sleep: Takes Naps: Yes No

Sleeps w/parent: Yes No

Sleeps thru night: Yes No

Min. 8.5hrs sleep/night: Yes No

Nightmare/problems: Yes No

Home Environment:

Home type: Apt Single-family Condo

Child exposed to Lead-based Paint? Yes No

Safety: Uses bike/skating helmet: Yes No

Car Seat Use: Faces Rear Faces Front

Booster None

Carbon monoxide detector: Yes No

Smoke detector: Yes No

School Name _____ **Grade** _____

Special Needs? Yes No

FAMILY HISTORY:

	Mother	Father	Sister	Brother
Alive & Well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Patient-Provider Agreement discussed by physician and given to patient.
Staff Initials:
Date:

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY

Print Patient Name (Last, First, Middle Initial) _____ Date of Birth _____

PLEASE READ THIS ENTIRE GENERAL CONSENT PRIOR TO SIGNING

GENERAL CONSENT FOR MEDICAL SERVICES

I give permission to the physicians, employees, and other people who work for or represent Wayne State University Physician Group ("WSUPG") to provide me with health care services. These services could include things such as tests to determine whether I am sick, physical exams, surgery, and normal medical tests and procedures (e.g., blood tests or flu shots). My physician will help me decide what services or supplies I will need. I understand that WSUPG's physicians, employees and other people who work for or represent WSUPG make no promises about the type of results I may have from any of these medical services or treatments. I also understand that WSUPG helps train physicians and other health care professionals and that students and physicians-in-training might be involved in my medical care.

If my physician thinks I should have a specific medical or surgical procedure, I understand that my physician will describe this procedure to me and explain how it will help me. I also understand that my physician will tell me about the negative things that could happen as a result of the procedure, as well as any other types of treatments or procedures that could help me.

CONSENT TO RELEASE OF MEDICAL INFORMATION

I understand that my medical information may be used by WSUPG and shared with other people or organizations, such as my insurance company and other health care providers, if the information is needed for reasons related to treatment, payment, or health care operations. I also understand that WSUPG might need information from other people or organizations that have already given me medical care. If WSUPG needs that information to help give me medical care now, I give permission to those other people or organizations, such as a hospital, another physician, a managed care company, or a pharmacy, to give WSUPG any and all of my medical information, including any information that is on paper and in a computer. I understand that the WSUPG Notice of Privacy Practices has more information about how my medical information could be used and shared.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

In exchange for the medical services provided to me by WSUPG and its physicians, I agree to pay the WSUPG medical bills when they are due, even if the services I receive will not be paid for by my insurance company. If I am late in paying the WSUPG bills, and my account is given to a lawyer or a collection agency, I understand and agree that I will be responsible for paying the attorney's fees, court costs, and any financial penalties a court may award to help collect the amount(s) I owe to WSUPG. I understand that my insurance company may require that I get permission before I receive health care services from WSUPG, and it will be my responsibility to make sure I get this permission from the insurance company. When WSUPG bills me for medical services that are not paid for by my insurance, I agree that I will pay those bills to WSUPG.

ASSIGNMENT OF BENEFITS

I give WSUPG the right to receive all of the money that my insurance company would normally pay to me for any services I receive from WSUPG. I understand that any positive balance in my WSUPG account may be used by WSUPG to pay any amount I owe WSUPG for services I receive. If there is any amount remaining in my account after paying for what I owe, WSUPG will pay (refund) that amount to me.

PATIENT INITIALS: _____

