Dr. Rohn and Dr. Gamble
6300 W Parker Rd Suite G24
Plano, TX 75093
972-378-0633

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Dallas, TX 75231
214-239-1641

Patient Intake Form- Pediatric **Date:** _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Date of Birth ____/____/_____

Age ____ Sex ___ Race _____ Ethnicity ____Hispanic ___Not Hispanic Preferred Language_____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____

PARENT/GUARANTOR INFORMATION

Name_____ Relationship to Patient _____ Date of Birth_____

Address_____City_____ State _____Zip _____

Home Phone_____ Cell Phone_____ Work Phone _____

How may our office best contact you? (Check one) _____Home Phone _____Cell Phone _____Work Phone

Preferred method of appointment reminder? _____Text _____Phone (circle: cell or home)

Email Address: _____Occupation_____

Emergency Contact:_____Relationship_____Phone number:_____

PHARMACY

Pharmacy Name _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

INSURANCE INFORMATION

Primary Insurance Carrier _____

ID# _____ _____

Group # _____

Subscriber Name _____

Subscriber Birth Date _____

Relationship to Patient _____

Secondary Insurance Carrier _____

ID# _____

Group # _____

Subscriber Name _____

Subscriber Birth Date _____

Relationship to Patient _____

REFERRING PHYSICIAN

Referring Physician Name _____ Practice Phone _____

Primary Care Physician _____ Practice Phone _____

May we thank someone else (non-physician) for referring you to our office? _____

ALLERGY INFORMATION

Drug Allergies _____Environmental Allergies_____

Are you allergic to latex? _____ Yes _____ No Are you allergic to medical tape? _____ Yes _____ No

SOCIAL HISTORY

Attend day care _____Yes _____No Pets in home _____Yes _____ No Cigarette Smoke exposure _____Yes _____No

Patient Name: _____ Date of Birth: _____

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

HEALTH HISTORY

What problems are you here for today? _____

Do you currently have or frequently experience:

____Allergy Problems ____Birth Defects/Syndrome ____Immune Deficiency ____ Respiratory
____Asthma ____Bleeding Disorders ____Heart Problems ____ Speech/Language Delay
____Anesthesia Problems ____Developmental Disorders ____ Neurological Problems
____Other:_____

Birth History Was your child born premature ____Yes ____No Gestational age at delivery _____
Complications of Prematurity _____
Prenatal Complications _____Current Weight _____Immunizations up to date ____Yes ____No
Did child pass newborn hearing screen ____Yes ____No ____Unsure Any current therapy (PT/OT/Speech)_____

Have you undergone any of the following surgeries?

Tonsillectomy Date: _____ Adenoidectomy Date:_____
Ear Surgery Date: _____ Thyroid Surgery Date:_____
Ear Tubes Date: _____ Nasal/Sinus Surgery Date:_____

Other_____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S= Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, Paternal Grandmother, Paternal Grandfather

____Alcoholism ____Cancer ____Heart Attack ____Lung Problem
____Anemia ____Chronic Ear Infections ____Heart Failure ____Mental Illness
____Arthritis ____Depression ____Hepatitis ____Reflux
____Atrial Fibrillation ____Diabetes ____High Blood Pressure ____ Sleep Apnea
____Asthma ____Emphysema ____High Cholesterol ____ Stroke
____Birth Defects ____Epilepsy/Seizures ____HIV/AIDS ____ Thyroid Problem
____Bladder Disease ____Glaucoma ____Kidney Disease ____Tuberculosis
____Bleeding Disorder ____Headaches ____Liver Problem ____Weight Loss/Gain

Other: _____

Patient Name:_____Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Do you frequently have or frequently experience: (Please check ALL that apply)

General ____**Healthy** ____ Prematurity ____Failure to thrive ____Fatigue ____Fever ____Weight Gain ____Weight Loss

Review of System ____**None** ____Hyperactivity ____Attention deficit ____Anxiety ____Depression

Allergy/Immunologic ____**None** ____Reactions ____Itching ____Sneezing ____Eye Irritation ____Immune Problems ____ Other: _____

Eyes ____**None** ____Strabismus ____Diminished visual acuity ____Discharge ____Other

Ears, Nose, Throat & Mouth ____**None** ____ Bruxism (teeth grind) ____Nose Blocked ____Voice Changes ____Pressure in ear ____ Difficulty Swallowing ____Nosebleed ____Ringing in ears ____Sinus Pain ____Sore Throat ____Other:_____

Endocrine ____**None** ____Hormone Problems ____Growth Disturbance ____Other:_____

Respiratory (Lungs) ____**None** ____Cough ____Shortness of Breath while Sitting ____Wheezing ____Shortness of Breath with Exertion

Cardiovascular (Heart) ____**None** ____Heart Murmur ____Syncope ____Chest Pain ____Cyanosis ____Irregular heart beat ____Other:_____

Gastrointestinal ____**None** ____GERD ____Constipation ____Diarrhea ____Indigestion ____Nausea ____Vomiting

Hematologic/Lymph Nodes ____**None** ____Anemia ____Blood disorder ____Bleeding easily ____Easy bruising

Genitourinary ____**None** ____Urination at Night ____Kidney Problems ____Other:_____

Musculoskeletal ____**None** ____Fractures ____Bone disease ____Painful Joints ____Weakness

Integumentary ____**None** ____Dry Skin ____Eczema ____Itchy skin ____Rash

Neurological (Nerves) ____**None** ____Meningitis ____Head Injury ____Dizziness/Vertigo ____Headache ____Seizures

Psychiatric ____**None** ____Hyperactivity ____Anxiety ____Depression ____Other:_____

Patient Comments: _____

_____

Signature of Patient/Guardian _____**Date**_____