

Vaccination Consult Intake Form
General information:

Name: _____

Age: _____

Date of birth: _____

 Address: _____

Phone: _____

Primary Care Giver:

Name: _____

Relationship to patient: (check)

mother ___ father ___ relative ___

family friend ___ other ___

 Address: _____

Phone (h): _____

Phone (w): _____

Who does the child live with? _____

What are the parents/care-givers occupations? _____

 How many siblings does your child have, and what age are they: _____

Are siblings, or your child in daycare or school? _____

Is your child adopted? Y N

What is your child's ethnic background? _____

Prenatal History:

How was both parents health at conception?

Mother: poor fair good unknown

Father: poor fair good unknown

What was mom's age at conception? _____

What was dad's age at conception? _____

What was mom's health like during pregnancy?

poor fair good unknown

Has mom contracted, or been vaccinated for:

	Age:	Reaction: (if any)
DTP (diphtheria, tetanus, pertussis) Y N	_____	_____
Tetanus booster Y N	_____	_____
Polio Y N	_____	_____
MMR (measles, mumps, rubella) Y N	_____	_____
Hemophilus influenzae (Hib) Y N	_____	_____
Varicella (chicken pox) Y N	_____	_____
Flu shot Y N	_____	_____
Hepatitis A/B Y N	_____	_____
Pneumococcal disease Y N	_____	_____
HPV (human papilloma virus) Y N	_____	_____

Birth History:

Term length (weeks): _____ Birth weight: _____ Any complications? _____

Type of birth: (vaginal, C- section)

How was the infant fed? Breast fed _____ For how long? _____

Formula fed _____ Type of formula (milk, soy, other) _____

How was the child's health at birth? Poor fair good

When were foods introduced? _____

Any food reactions? _____

Medical History:

Surgeries/ Hospitalizations:

Condition: _____	Year: _____
_____	_____
_____	_____
_____	_____

Allergies:

Food: _____

Chemical/drug: _____

Other: _____

Condition	Year	Condition	Year
Diaper rash		Chicken pox	
Cradle cap		Measles	
Eczema		Mumps	
Psoriasis		Rubella	
Fever		Lice	
Roseola		Impetigo	
Urinary tract infection		Cold sores	
Frequent colds		Bed-wetting	
Worms		Broken bones	
Warts		Sprains, strains	
Whooping cough		Nightmares	
Constipation		Poor sleep	
Diarrhea		Deafness	
Asthma		Ear infections	
Excessive thirst		Changes in appetite	

Please list any medications, with dosage:

Has your child ever been on antibiotics? _____

Please list any supplements, vitamins..., with dosage:

What is your child's diet like?

Developmental History:

How was the child's health for the first year: poor fair good unknown

Did your child meet his/her developmental milestones on time? Y N

Are there any pets at home? Y N

Does anyone in the home smoke? Y N

Do you live on a farm? Y N

Does anyone in the home have a chronic disease? Y N _____

Do you plan to travel outside of North America with your child? Y N

Are there needles in your household, where your child might be able to access? Y N