SUNSHINE
COMMUNITY HEALTH CENTER

Talkeetna Clinic
Mile 4.4
Talkeetna Spur Rd.
(907) 733-2273
HC89 Box 8190
Talkeetna, AK 99676

Willow Clinic
24091
Long Lake Rd.
(907) 495-4100
PO Box 1049
Willow AK 99688

Wasilla Clinic
950 E. Bogard Rd.
Suite #233
(907) 376-2273
950 E. Bogard Rd., #233
Wasilla AK 99654

Pediatric Patient Intake Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Parents' Names: _____ School & Grade: _____

Allergies: ☐ None _____ Vaccines Up To Date? Y ☐ N ☐ Unsure ☐

Current Medications, Vitamins, Supplements: ☐ None _____

Patient's Health Problems: _____

Hospitalizations / Surgeries / Injuries: _____

Has the patient EVER had any of the following?

Anemia/Bleeding tendency	□ Y □ N	Seizure or Epilepsy	□ Y □ N
Ear infections	□ Y □ N	Heart disorder/defect	□ Y □ N
Asthma/Breathing problems	□ Y □ N	Cancer/Leukemia	□ Y □ N
Growth disorder	□ Y □ N	Kidney/Bladder problems	□ Y □ N
Behavioral problems	□ Y □ N	Liver disease	□ Y □ N
Eye Disorder	□ Y □ N	Developmental disorder	□ Y □ N
Blood Transfusion	□ Y □ N	Thyroid disorder …….	□ Y □ N

Review of Systems: Please indicate ALL that the patient has experienced within the past 6 months.

Fever	□Y□N	Fatigue	□Y□N	Night Sweats	□Y□N
Chills	□Y□N	Weight gain	□Y□N	Sleep Disturbance	□Y□N
Vision Problems	□Y□N	Weight loss	□Y□N	Earache	□Y□N
Red Eyes	□Y□N	Light Sensitivity	□Y□N	Runny Nose	□Y□N
Double Vision	□Y□N	Decreased Hearing	□Y□N	Abdominal pain	□Y□N
Shortness of Breath	□Y□N	Sore Throat	□Y□N	Diarrhea	□Y□N
Wheeze	□Y□N	Coughing up Blood	□Y□N	Decreased appetite	□Y□N
Vomiting	□Y□N	Chest Congestion	□Y□N	Constipation	□Y□N
Recurrent Headache	□Y□N	Rapid Breathing	□Y□N	Blood in stool	□Y□N
Dizziness	□Y□N	Poor Coordination	□Y□N	Nausea	□Y□N
Weakness	□Y□N	Numbness/Tingling	□Y□N	Fainting (syncope)	□Y□N
Painful urination	□Y□N	Seizures	□Y□N	Concussion	□Y□N
Frequent urination	□Y□N	Irregular menses	□Y□N	Rash	□Y□N
Nocturia	□Y□N	Heavy menstrual bleed	□Y□N	Itching	□Y□N
Depression	□Y□N	Aggression	□Y□N	Unusual growth	□Y□N
Anxiety	□Y□N	Difficulty concentrating	□Y□N	Dry skin	□Y□N
Excessive thirst	□Y□N	Easy bleeding	□Y□N	Easy bruising	□Y□N
Heat/cold intolerance	□Y□N	Hair changes	□Y□N	Swollen lymph nodes	□Y□N
Skin Changes	□Y□N	Other:			

Does your child's primary water source contain fluoride?	□Y □N □Unsure
Does your child have a dentist (9 months and up)?	□Y □N □Unsure □ N/A
Does your child's diet contain iron rich foods such as meat, fortified cereals, or beans?	□Y □N □Unsure
Do you struggle to put food on the table?	□Y □N □Unsure
Does anyone smoke around the patient?	□Y □N □Unsure
Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	□Y □N □Unsure
Does you child have a parent with an elevated blood cholesterol level (240 mg/dl or higher) or who is taking cholesterol medicine?	□Y □N □Unsure
Was your child or a household member born in or ever traveled to a country where Tuberculosis is common (includes countries in Africa, Asia, Latin America, and Eastern Europe)?	□Y □N □Unsure
Has your child come in close contact with a person who has Tuberculosis disease or who has had a positive tuberculosis test?	□Y □N □Unsure
Does your child live in or visit a home or childcare facility with identified lead hazard or that was built before 1960 that is in poor repair or recently renovated?	□Y □N □Unsure

Please list any known medical problems in family including siblings, parents, grandparents:_____

_____