IRMA GONZALEZ M.D., F.A.A.P.
PEDIATRICS
960 East Green Street, Suite L-12
Pasadena, California 91106
Phone (626) 795-8822 Fax (626) 795-8823

PATIENT INFORMATION

Patient

Last Name__________________ First Name____________________ Middle Name______________________

Date of Birth________________ Preferred Contact Phone________________________

Address_______________________________ City____________________State___ Zip_________________

Parent / Guardian #1

Last Name__________________ First Name__________________________ Date of Birth________________

Home Phone________________ Mobile Phone________________________

Address (if different than above)______________________________City______________ State___ Zip______

Occupation_________________ Employer___________________________ Work Phone_________________

Email address:____

Parent/Guardian #2

Last Name__________________ First Name__________________________ Date of Birth________________

Home Phone________________ Mobile Phone________________________

Address (if different than above)______________________________City______________ State___ Zip______

Occupation_________________ Employer___________________________ Work Phone_________________

Emergency Contact (other than person's listed above)

Name_____________________ Phone______________________________ Relationship_________________

Pharmacy

Name_____________________ Phone______________________________ Address_____________________

I agree to assign insurance benefits to my child's doctor whenever necessary. I understand that I am financially responsible for all charges whether or not they are covered by the insurance. I authorize Dr. Gonzalez to treat my child. I understand that failure to cancel an appointment without 24-hour notice will result in a $25.00 fee.

Signature__________________ Relationship to Patient____________________ Date____________________

Pediatric Initial Intake History Form

Patient Name____ DOB____________________________
Person Completing Form______________________________________ Relationship to Patient______________

Mother's History
#of Pregnancies____ # of Live births_____ # of Miscarriage/Abortion_____ # of Stillbirths______
What month did mother start prenatal care?________________
Mother's Age at Pregnancy?____________ Mother's Age at Birth of Child?_______________
During Pregnancy, did Mother use / have any of the following?
[ ]Alcohol Use [ ]High Blood Pressure [ ] Prescription Medication [ ]Over the Counter Medication [ ]Smoking
[ ]Street Drug Use [ ] Anemia [ ]Infections [ ]Seizures [ ] Swelling of Hands / Feet [ ]Seizures [ ] Diabetes
[ ] Other____
Comments:____
____

Birth History
Place of Birth____ City____
Birth Weight ______________________________ Length________________________ Head Circumference____________
Gestation [ ]Full Term [ ]Premature ___________weeks [ ] Vaginal [ ] C-Section
Complications [ ] Yes (give details below [ ] No
Comments:____
____

Neonatal History
Check any problems during the first month
[ ]Anemia [ ]Diabetes [ ] High Blood Pressure
[ ]Infections [ ]Prescription Medications
[ ]Over the Counter Medications [ ]Re-Hospitalization
[ ]Seizures [ ]Transfusions [ ]Other___________
Comments:____
____

Adolescent History (Complete for ages 12-21 ONLY)
Any of the following problems / concerns?
[ ]Alcohol Use [ ] Cigarette Use [ ]Eating Disorder
[ ]Has children [ ]Family Problems [ ]Sexual Activity
[ ]School Problems [ ]Street Drug Use
[ ]Sleep Issues [ ]Other________________________
Comments:____
____

Female Adolescent History
Has menstruation begun? [ ]Yes [ ]No
If so, at what age? ________
Date of last menstrual cycle______________________
Frequency- How Every _______ Days
Duration- Lasts ______Days
Has patient ever been pregnant? [ ]Yes [ ]No
Comments:____

Childhood History (Complete for ages 1 month and older)
Has the child had any of the following?
[ ]Anemia/Blood Disorder [ ]Asthma [ ]Drug Allergies
[ ]Hospitalization [ ]Poisoning [ ]Rheumatic Fever
[ ]Seizures [ ]Serious Injury [ ]Surgery [ ]Tuberculosis
Comments:____
____

Any of the following problems?
[ ]Development [ ]E/N/T [ ]Eyes [ ]Ears [ ]Heart
[ ]Muscles/Bones [ ]Nervous System [ ]Psychological
[ ]Respiratory [ ]Skin [ ]Stomach/Colon (GI)
[ ]Teeth/Gums [ ]Urinary Tract (GU) Other________________
Comments:____
____

Social History
Where does family live? [ ]House [ ]Apartment
[ ]Motel [ ]Trailer [ ]Other__________________
Child Lives with [ ]Both Parents [ ]Mother [ ]Father
[ ]Father Works [ ]Mother Works [ ]Guns in home?
Comments____

Family History
Present age of Mother _____ Father_____ Number of siblings (alive)__________
Check serious illness/disease below:

Mother/ Mothers Family
[ ]Alcohol/Drug Use [ ]Asthma [ ] Diabetes
[ ]Epilepsy [ ]Heart Disease [ ]High Blood Pressure
[ ]High Cholesterol [ ]HIV (AIDS) [ ]Cancer
[ ]Blood Disease [ ]Developmental Problems
[ ]Mental Illness [ ]Thyroid Problems [ ]TB
Other___________________________________

Father / Fathers Family
[ ]Alcohol/Drug Use [ ]Asthma [ ]Diabetes
[ ]Epilepsy [ ]Heart Disease [ ]High Blood Pressure
[ ]High Cholesterol [ ]HIV (AIDS) [ ]Cancer
[ ]Blood Disease [ ]Developmental Problems
[ ]Mental Illness [ ]Thyroid Problems [ ]TB
Other____

Comments:____

____ ________________________
Reviewed by Provider **(Dr. Irma Gonzalez, MD FAAP)** Date

Irma Gonzalez, M.D.

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize ____
(**Previous** Physician/Healthcare Facility)

To release the following information regarding patients medical history:

[ ] Immunization Records
[ ] Growth Charts
[ ] Lab Results
[ ] Notes pertaining to chronic medical condition

Please fax these records to the fax number listed above.

If the above records exceed more than 10 pages, please mail to our office.

This authorization shall be effective immediately and remain in effect for one year from the date below. A photocopy of facsimile of this authorization shall be considered as valid as the original.

____
Signature of parent/legal guardian

____
Relationship to patient

____
Patient's Name (Please Print)

____
Patient's Date of Birth

____
Witness Name (Please Print)

____
Date