CORVALLIS FAMILY MEDICINE, P.C.
Established Patient Child (0-12) Intake Questionnaire

Name:_____ Date:_____

DOB:_____ Sex: Male / Female / Transgender / Other: _____

Family History

If no changes in the last year, please check here and skip to Social History ☐

Note any changes here

(check all that apply)

Relative	Are they alive?	Current Age (or at death)	Diabetes	High blood pressure	Heart disease	Stroke	Psychologic	Breast cancer	Prostate cancer	Colon cancer	Other (please specify)
Father	Y / N										
Mother	Y / N										
Brother(s)	Y / N										
Sister(s)	Y / N										
Son(s)	Y / N										
Daughter(s)	Y / N										
Paternal Grandfather	Y / N										
Paternal Grandmother	Y / N										
Maternal Grandfather	Y / N										
Maternal Grandmother	Y / N										

Social History

Tobacco	Are there any smokers at home?		Yes	No	
Alcohol	Have you had a drink in the last year?		Yes	No	
Drug use	Never	Past Use	Current Use	Drugs of choice:	
Marijuana use	No	Occasional	Daily or almost daily		
Orientation	Straight	Homosexual	Bisexual	Other:	
Are you sexually active?	Yes	No	Unknown by parents / guardians		
Extracurricular activities (clubs, sports, dance, etc.)					
Exercise	How often?		Types:		
Caffeine	How much per day?		Types:		
How many hours in front of a screen per day? (TV, computer, cell phone)					
Do you have any developmental concerns?	Social	Verbal	Physical / Motor		

Preventative screenings	Month/Year (approx.)
Last physical exam / well child check	

Females only	
Have you started having periods?	
Are your periods regular?	