

VCU International Adoption Medical Clinic

Patient Intake Form

Please fill in as much information as possible and bring copies of original records and any x-rays (copies or originals) that have been provided to your first appointment. If possible, please fax or mail particularly complex records, or those requiring translation, ahead of time.

1. Child's Current Given Name: Last Name:
First Name: Middle Name: Nickname:
2. Child's Birth Name or Name given in country of Origin:
3. Date of Birth:
4. Adoptive Parent's name(s):
5. Who else lives at home (names, ages):
6. Country of Origin:
7. City, Province, District or State?:
8. Circumstances (orphanage or foster care?):

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9. Adoption Agency Used?:

10. Date of Arrival in United States?

11. Date Adoption Completed (if incomplete, estimate date):

12. Current residence (city, state):

13. Which physicians have already seen your child?

PCP:

Specialists:

14. Any medical information from birth parents (including medical history, family history, social situation, drug/alcohol history, etc.)

15. **Birth History**

Vaginal Delivery

Caesarean section

Full Term

Premature

How early? _____

Birth Weight: Height: Head circumference:

Age at separation from birth parents & reasons (if known):

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16. Past Medical History:

Hospitalizations (dates and reason):

Any Surgeries (dates and reason):

Other documented medical problems (whether they appear to be real or not) and treatments if known:

Review of Systems:

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Medications:

Allergies to medications:

What laboratory testing has been done since arriving in the US?

17. Does your child...

Have a history of fever: Yes No

Have runny nose or ear problems Yes No

Have diarrhea, loose, or foul smelling stools Yes No

Have constipation Yes No

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Have a cough Yes No

Have a rash Yes No

Does your child?

Spit up, choke, cough, or gag with drinking Yes No

“Play” with the bottle/cup – drink small amts Yes No

Hoard or overstuff with solids: Yes No

If bottle feeding do you use high flow/cut nipple Yes No

Sleep through night, take naps, snore, gasp? Yes No

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18. Do you have any concerns regarding your child's:

Vision: Yes No

Hearing: Yes No

Breathing: Yes No

Do you have any concerns regarding your child's:

Heart: Yes No

Urination or kidneys: Yes No

Skin: Yes No

Anemia or blood problems: Yes No

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Immune system: Yes No

Behavior: Yes No

Social Skills: Yes No

Language: Yes No

Development: Yes No

19. Behavioral History

Does your child:

Bite/hit/scratch: Yes No

Have Temper Tantrums: Yes No

Head bang/rock: Yes No

Seek you out for cuddle/hug Yes No

Seek you out if hurt Yes No

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Go to anyone for affection Yes No

Can your child:

Roll over front to back: Yes No

Sit alone: Yes No

Crawl: Yes No

Walk holding on Yes No

Run: Yes No

Go up stairs holding Yes No

Push buttons on toys Yes No

Scribble Yes No

Hold fork or spoon Yes No

Can your child:

Coo (ahh, ooh) Yes No

Babble (ba-ba, ma-ma) Yes No

Say single words (in native) Yes No

Talk in 2-3 words(in native) Yes No

Point to objects Yes No

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Make good eye contact Yes No

Turn to look if name called Yes No

20. Any other concerns about your child?

Housekeeping Issues

Although necessary blood and urine samples will be obtained for testing at the time of your clinic visit, stool samples can be difficult to produce on demand for many children! A fresh (preferably < 2 hours old) stool sample can be brought in and processed for parasite and bacterial exams. A sample in a diaper (preferably in a plastic bag) is acceptable. If stools are very loose, a piece of plastic wrap inside the diaper will keep the sample from being absorbed too much.

Please mail or fax your information to:

VCU IAMC

Attn: Dr. Suzanne Lavoie

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