P**ATIENT INFORMATION**

Name (Last, First, M.I.) ­­­­­­­­­­ \_\_\_\_(Circle) Male Female\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth / / / Age:\_\_\_\_\_\_\_\_\_ \_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Home Phone | Preferred Pharmacy Name and Location |
| Cell Phone | Primary Dentist |
| Address | Email Address |

**PARENT(S) INFORMATION**

Name person completing form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s full name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_

Mom SSN & Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father SSN & Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Name & Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is primary caregiver?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child lives with who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT**

What is the primary concern today?

Check here if you would like to discuss anxiety or depression or behavior changes in your child with the MD

**Describe the course of this illness:**  Stable Progressive Improving

**List symptoms of today’s illness:**

Rash Y\_ N\_ Pain Y\_ N\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headache Y\_ N\_ Fever Y\_ N\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vomiting Y\_ N\_ What was the highest temperature?

Diarrhea Y\_ N\_ Was Tylenol or ibuprofen given? When?

**MEDICAL HISTORY - circle any additional medical symptoms or diagnoses that apply for your child.**

**Neurological:** Spina bifida Dizziness Seizures Headaches such as migraine

**Ears:**  Frequent ear infections Ear tubes Trouble hearing

**Throat:** Frequent strep throat Tonsil and/or Adenoid removal? Y\_\_\_\_ N\_\_\_\_\_

**Endocrine** Diabetes Fatigue Weight gain or loss Thyroid

**Growth:** Failure to thrive Short stature

**Lungs:**  Asthma RSV Bronchitis Shortness of breath Pneumonia

**Heart:** Congenital heart disease Irregular heart beat Chest pains High blood pressure Passing Out Fatigue

**Blood:** Anemia Low platelets Low white count Unexplained bleeding Unexplained bruising

**Stomach/Intestines:** Abdominal pain Inflammatory bowel disease Celiac disease Constipation Reflux Frequent diarrhea Vomiting

**Bladder/Kidney:**  Urinary tract infections

**Genitalia:**  Undescended testicles Hypospadias Vaginal stenosis Vaginal discharge

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**Muscles/Joints:**  Increased joint flexibility Poor coordination Arthritis Joint dislocations Muscle pain

Contracture Joint pain

**Skeletal:**  Low bone density Scoliosis Abnormal bone age Fractures

Pectus excavatum (sunken chest) Pectus carinatum (pigeon chest)

**Other:** Developmental concernsSpeech concerns

**ALLERGIES**  Yes No

*List drug allergy & other pertinent allergies such as bees, latex, adhesive, shellfish, food*

1. 3. 2. 4.

**PHARMACY AND MEDICATION LIST** *Please list all current meds below.*

**Prescription meds. Please list both long term and those used for this episode.**

**Non-prescription meds. Please list meds used regularly and for this episode.**  **Name: Using Currently:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Yes No

**SURGERIES AND HOSPITALIZATIONS** **Type Hospital/Doctor Date**

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| **FAMILY HISTORY** | |
| **Does your child have any relatives with the following problems? Check off if problem in family history and write in relationship next to the problem.** | |
| Asthma | Learning issues: |
| Anemia: | Limb defects: |
| Arthritis: | Mental retardation: |
| Autism spectrum disorder: | Mental illness: |
| Birth defect: | Metabolic problem: |
| Blindness or eye disorder: | Muscular dystrophy: |
| Bone disorder: | Multiple miscarriages: |
| Cancer: | Neurofibromatosis: |
| Chromosome abnormality: | Neurologic disorder: |
| Cleft lip/palate: | Seizures: |
| Clots (blood): | Short stature (<5’0”): |
| Cystic fibrosis: | Skeletal abnormality: |
| Diabetes | Skin disease: |
| Heart defect: | Spinal muscular atrophy: |
| Hemophilia: | Spina bifida: |
| Huntington disease: | Strokes Age of occurrence |
| Hydrocephalus: | Tall stature (>6’0”) |
| High blood pressure: | Urinary tract abnormality: |
| Infertile: | Heart attack Age of occurrence |
| Intellectual disability: | Kidney disease |
| Other | |

|  |
| --- |
| Smoke exposure: (does patient ?) smoke vape chew tobacco exposure to 2nd hand smoke |
| Alcohol use: Type Frequency |
| Drug use: Type Frequency |
| Guns: In the home? Locked? |
| Car safety: Car seat use? Seat belt use? |

|  |  |
| --- | --- |
| **IMMUNIZATIONS** | **Please attach vaccine records** |
| **Year** | **Immunization** |
| Last yr\_\_ this year\_\_\_ | Influenza |
|  | Tetanus |
|  | Other (please specify) |

|  |  |  |
| --- | --- | --- |
| **BIRTH HISTORY** | | |
| Length: | | Gestational age: |
| Weight: | Delivery method: | |
| Head circumference: | Duration of labor: | |
| Discharge weight: | Feeding method: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **HOSPITAL INFORMATION** |  | | |
| Days spent in the hospital | Hospital Name | | |
| **Did your child spend time in the NICU (Neonatal intensive care unit)?** | | Yes | No |
| *Please Explain:* | | | |

**Travel and Exposure Questionnaire**

Have you traveled outside the U.S. in the last month?

YES NO

Have you had contact with someone with a communicable disease in the last month?

YES NO UNKNOWN

If yes, please circle:

Chicken pox Cholera Cold Ebola Enterovirus Influenza Measles Meningitis MERS Tuberculosis Unidentified

Other (Please Comment)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exposure Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have symptoms below occurred in the last week? If yes, please circle:

Abdominal Pain Cough Diarrhea Fever Muscle Pain

Severe Headache Bruising or Bleeding Vomiting Weakness Rash