



Today's Date: _____

Physician: _____

Print Name: (last) _____ (first) _____ Date of Birth: _____

Language spoken at home: _____

MEDICATIONS:

Please list all medications (including over-the-counter, vitamins, and/or supplements)

NAME	STRENGTH	FREQUENCY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

ALLERGIES:

Is patient allergic to any drugs or medications?

No Yes If yes, what?

Does the patient have any food allergies?

No Yes If yes, what?

Does the patient have any other allergies?

No Yes If yes, what?

REVIEW OF SYSTEMS: Please check any symptoms you have had RECENTLY

Constitutional

- Chills
- Decreased activity
- Decreased appetite
- Fever
- Fussiness
- Weight gain
- Weight loss

HEENT

- Difficulty swallowing
- Ear drainage
- Esotropia (cross eye)
- Eye discharge
- Eye redness
- Headache
- Hearing loss
- Nasal congestion
- Ear pain
- Sore throat
- Runny nose
- Sneezing
- Tearing
- Visual loss

Respiratory

- Breathing difficulty
- Use of accessory muscles
- Cough
- Sputum
- Wheezing

Cardiovascular

- Chest pain
- Palpitations
- Fainting

Vascular

- Cool extremity
- Blue coloration

Gastrointestinal

- Abdominal pain
- Constipation
- Diarrhea
- Nausea
- Reflux
- Vomiting

Genitourinary

- Decreased urine output
- Painful urination
- Urinary incontinence
- Flank (side) pain
- Foul urine odor
- Blood in urine

**Reproduction
(Male Only)**

- Circumcised
- Penile discharge
- Scrotum testicular mass
- Scrotum testicular pain

Metabolic/Endocrine

- Excessive thirst
- Excessive urination

Neurological

- Inappropriate interaction
- Behavioral changes
- Inconsolable
- Difficulty concentrating
- Distorted body image
- Self conscious

Skin

- Acne
- Itching
- Rash
- Skin lesion

Musculoskeletal

- Bone pain
- Joint pain
- Joint swelling
- Muscle weakness
- Muscle pain

Hematologic/Lymphatic

- Easy bleeding
- Easy bruising
- Enlarged lymph nodes

Immunologic

- Seasonal allergies
- Environmental allergies
- Food allergies
- Urticaria (Hives)

Name: _____ DOB: _____

MEDICAL CONDITIONS: Please mark any illness or disease the patient has had in the past or currently may have:

- | | | | |
|--------------------------------------------|---------------------------------------------------|----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vesicoureteral reflux |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Concussion | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Heart murmur | Specify _____ |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear infections, recurrent | <input type="checkbox"/> Genetic disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fracture(s) | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Developmental issues |
| <input type="checkbox"/> Birth Trauma | Specify _____ | <input type="checkbox"/> Kidney infection | |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> GERD | <input type="checkbox"/> Seizure disorder | |
| <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Seizures, febrile | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Headache, migraine | <input type="checkbox"/> Urinary tract infection | |

SURGICAL/HOSPITALIZATION HISTORY: (if marking an item below please include the year it occurred)

- | | | |
|--------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Adenoidectomy _____ | <input type="checkbox"/> Hernia Repair, inguinal _____ | Other _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hernia Repair, umbilical _____ | <input type="checkbox"/> Tympanostomy (Ear Tubes) |
| <input type="checkbox"/> Blood transfusion _____ | <input type="checkbox"/> Lymph node biopsy/excision _____ | Right Left Both |
| <input type="checkbox"/> Dental surgery _____ | <input type="checkbox"/> Tonsillectomy _____ | |

What diagnostic, screening studies or immunizations has the patient had previously? Please list most recent date.

Complete Physical _____ Last Eye Exam _____ Last Hearing Test _____

Has child had all immunizations for his/her age? _____ If not, reason _____

Which ones are missing? _____ Can we give them today? _____

Name: _____ DOB: _____

FAMILY HISTORY: Check below to report problems the patient's family members have had. Please state age when they had the problem if you know it and if this was a cause of death.

Adopted (unknown family history)

Condition	Whom	Onset Age	Cause of Death?
ADD/ADHD			
Allergies			
Asthma			
Birth defects			
Cancer (list type)			
Heart disease			
Deafness			
Depression			
Developmental delay			
Developmental dislocation of hip			
Diabetes			
Eczema			
Elevated lipids			
Genetic disease			
Hemoglobinopathy (blood disorder)			
Hypertension			

Condition	Whom	Onset Age	Cause of Death?
Learning disability			
Mental retardation			
Migraines			
Obesity			
Kidney disease			
Scoliosis			
Seizure disorder			
Sudden infant death syndrome (SIDS)			
Thyroid disease			
Alcoholism			
Substance Abuse			
Mental Illness			
Celiac Disease			
Stroke			
Other			

RELATIONSHIPS:

Child Care Provider: _____ Number of days/week _____

Who lives at the primary residence? _____ Who lives at the secondary residence? _____

Marital status of parents: _____

Siblings: How many? _____ Birth order: _____

Smokers at home? No Yes If yes, smoke outside only? No Yes

HOME ENVIRONMENT:

Is there lead in the home? No Yes Removed Unknown

Uses bike/skating helmet: No Yes

Car restraints: Car seat: face rear Booster None
 Car seat: face front Seat belt

Carbon Monoxide Detectors in home: No Yes

Smoke Detectors in home: No Yes

Radon in home: No Yes Untested Treated

Pets/animals at home: No Yes If yes, what kind? _____

Firearms at home: No Yes If yes, locked storage: No Yes
Ammo stored separately: No Yes

Name: _____ DOB: _____

SLEEP:

Take naps: No Yes
Sleeps with parents: No Yes
Sleeps through the night: No Yes
Nightmare/sleep problems: No Yes

ACTIVITY:

Exercise/sports/activity: _____ hours/day Type of exercise/sport? _____ Type of activity? _____
TV/computer games: _____ hours/day Has TV in bedroom? No Yes
Internet: _____ hours/day Has computer in bedroom? No Yes

NUTRITION: (under 5)

Concerns: No Yes _____

Milk: _____ ozs/day

Liquid: Drinks from: Bottle Cup Breast

Duration: _____ Frequency: _____

Solid: Baby Food Table Food

Age solids introduced: _____ months

Caffeine: No Yes

Bladder Toilet Trained: No Yes Day Only

Age trained _____ months

Bowel Toilet Trained: No Yes

Age trained _____ months

Last Dental Visit: _____

DEVELOPMENTAL HISTORY:

Did your child achieve developmental milestones in an age appropriate matter? _____

Please list all specialty Physicians that you have seen in the last year:

Provider Name: _____

Provider Name: _____

Specialty: _____

Specialty: _____

Phone Number: _____

Phone Number: _____

Reason/Diagnosis: _____

Reason/Diagnosis: _____

Please list the patient's mail order and/or primary pharmacy:

Pharmacy: _____

Pharmacy: _____

Address: _____

Address: _____

Phone No.: _____

Phone No.: _____

The above information is correct to the best of my knowledge.

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one

Date