

Patient Name: _____

PCP: _____

Date: ___/___/___

Pediatric Initial Visit (p. 1): Please provide the following medical information to the best of your ability:

Age: _____	DOB: ___/___/___	List any ALLERGIES TO MEDICATIONS:	
What problems are you here for today?		_____	
_____		_____	
_____		_____	
Past Medical History:			
1) Please check the "Yes" or "No" box to indicate if the patient has any of the following illnesses; for "Yes" answers, please explain			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
Premature birth	<input type="checkbox"/> <input type="checkbox"/>	_____	Allergy problems/therapy <input type="checkbox"/> <input type="checkbox"/>
Complication during pregnancy	<input type="checkbox"/> <input type="checkbox"/>	_____	Neurological problems <input type="checkbox"/> <input type="checkbox"/>
Significant injuries	<input type="checkbox"/> <input type="checkbox"/>	_____	Ear problems <input type="checkbox"/> <input type="checkbox"/>
Asthma / lung problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Immune deficiency <input type="checkbox"/> <input type="checkbox"/>
Heart problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Are immunizations up to date <input type="checkbox"/> <input type="checkbox"/>
Stomach or intestinal problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Bleeding problems <input type="checkbox"/> <input type="checkbox"/>
Kidney problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Skin problems <input type="checkbox"/> <input type="checkbox"/>
		_____	Other Medical Diagnosis <input type="checkbox"/> <input type="checkbox"/>
2) Please list any operations (and dates) the patient has ever had (including tonsils & adenoids):			

3) Please list any current medications on the enclosed green Patient Medication List			
4) Please list your child's favorite foods: _____			
5) Please indicate any special therapy: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Other _____			
Social History:		Please list details below:	
Does child attend day care?	<input type="checkbox"/> <input type="checkbox"/>	_____	
Are there pets in the house?	<input type="checkbox"/> <input type="checkbox"/>	Describe _____	
Is there smoke exposure?	<input type="checkbox"/> <input type="checkbox"/>	Tobacco? Yes / No	Wood? Yes / No How much? _____
Child's primary residence? _____		Secondary or other residence? _____	
School grade? _____		Describe any special schools or classes _____	
Family History:			
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:			
If yes, please indicate which relative(s) have the problem			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
Hearing or balance problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Asthma / lung problems <input type="checkbox"/> <input type="checkbox"/>
Allergy / Sinus problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Heart Problems <input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____	Headaches <input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____	High blood pressure <input type="checkbox"/> <input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/> <input type="checkbox"/>	_____	Other health problems <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> See attached dictation		Reviewed by: _____	

Patient Name: _____

Date: ____/____/____

Pediatric Initial Visit (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:								
1) Please check the "Yes" or "No" box to indicate whether the patient presently has any of the following symptoms:								
2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for the visit today								
		Yes	No	Current		Yes	No	Current
GENERAL	fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	seasonal allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	passing out / seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	eye pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENT	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	swelling neck or face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ear pressure / fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent "sinus infec"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	discolored nasal dischg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent throat infec	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	snoring with pauses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR.	cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bowel irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	increased urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSK	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> See attached dictation								
Reviewed by: _____								

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Environment Review: Please complete details of all the sections that apply to you

	Yes	No		Yes	No
Do you live in the city?	<input type="checkbox"/>	<input type="checkbox"/>	Do you work outdoors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in the country?	<input type="checkbox"/>	<input type="checkbox"/>	Do you work indoors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live on a farm?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have increased symptoms at school or work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trees and/or lawn?	<input type="checkbox"/>	<input type="checkbox"/>	List any school or work related allergy/sinus symptoms		
Do you live in a house:	<input type="checkbox"/>	<input type="checkbox"/>			
Age of house, years lived there	_____/_____				
Do you live in an apartment/condo?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use a mask when you clean, mow, or sweep?	<input type="checkbox"/>	<input type="checkbox"/>
Age and years lived there	_____/_____		Do you have feather pillows?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in a mobile home?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have down comforters?	<input type="checkbox"/>	<input type="checkbox"/>
Age and years lived there	_____/_____		Do you use pillow/mattress covers?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a basement/crawl space?	<input type="checkbox"/>	<input type="checkbox"/>			
Is it wet or dry?	_____		Do you have frequent exposure to:	(if yes, circle:)	
Do you have carpeting?	<input type="checkbox"/>	<input type="checkbox"/>	Dog	<input type="checkbox"/>	<input type="checkbox"/>
Age and amount?	_____		Cat	<input type="checkbox"/>	<input type="checkbox"/>
Have you remodeled lately?	<input type="checkbox"/>	<input type="checkbox"/>	Bird	<input type="checkbox"/>	<input type="checkbox"/>
Do you have indoor plants?	<input type="checkbox"/>	<input type="checkbox"/>	Rodents	<input type="checkbox"/>	<input type="checkbox"/>
Are there smokers in your home, apartment, or condo?	<input type="checkbox"/>	<input type="checkbox"/>	Livestock	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hepa filter?	<input type="checkbox"/>	<input type="checkbox"/>	Other (list)	<input type="checkbox"/>	<input type="checkbox"/>
What type of heating system?	_____				
What type of cooling system?	_____				

PLEASE STOP HERE

See attached dictation

Reviewed by: _____