

Patient Name: \_\_\_\_\_

Chart Number \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

<b>Date:</b> _____	<b>Age:</b> _____	<b>List any ALLERGIES TO MEDICATIONS:</b>
<b>What problems is the patient here for today?</b>		
<b>Past Medical History:</b>		
1) Please check the "Yes" or "No" box to indicate if patient has any of the following illnesses; for "Yes" answers, please explain		
	<b>Yes</b>	<b>No</b>
<b>Infections during pregnancy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Complication during pregnancy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Significant injuries</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory problems</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heart problems</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Stomach or intestinal problems</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Kidney problems</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER MEDICAL DIAGNOSIS</b>	<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 (and amounts, times per day);		
<i>(including aspirin, antacids, vitamins, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):</i>		
4) Please indicate any special therapy: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Other		
<b>Social History:</b>		
	<b>Yes</b>	<b>No</b>
Does child attend day care?	<input type="checkbox"/>	<input type="checkbox"/>
Are there pets in the house?	<input type="checkbox"/>	<input type="checkbox"/>
Is there smoke exposure?	<input type="checkbox"/>	<input type="checkbox"/>
Who does child live with?	<input type="checkbox"/>	<input type="checkbox"/>
School grade? _____	Describe any special schools or classes _____	
<b>Family History:</b>		
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 and the nature of their problem		
	<b>Yes</b>	<b>No</b>
Hearing or balance problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
		<b>Reviewed by:</b> _____

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

<b>Review of Systems:</b>								
		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 patient's 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"/>
	sweats	<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	<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"/>
	dizziness, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mouth breathing	<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"/>
	throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat dryness/itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR.	cough / cough w blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noisy breathing	<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, reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	eating prob/anorexia	<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"/>
	blood in urine	<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"/>
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 / hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	strawberry birth mark	<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"/>
PLEASE SIGN AND DATE: _____					Date: ____/____/____		<b>PLEASE STOP HERE</b>	
<input type="checkbox"/> See Dictated Note								
Reviewed by: _____								