Rocky Mountain Pediatric Infectious Disease Consultants

Health ONE

RockyMountainKidsID.com

Initial Visit

Childs Name:	Age:	DOB:
Reason for Today's Visit:		

Current Medications (if your child is on chronic medications, list how many times your child has missed a dose in the last 2 weeks)

Medication Name	Dose	Frequency	Duration

Medical History: (If return visit ONLY note any changes) – Are you Breast Feeding [ ] Yes [ ] No

Allergies/Intolerance	Reaction

Past Surgical History & Date	Hospitalization & Date (if within 6 months)

Rocky Mountain Professional Plaza 2055 N. High Street, Suite 190 Denver, CO 80205 Office 303.393.4300 Fax 303.832.7205

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Family History – Please indicate with an X

Family Member	Diabetes	HTN	Breast CA	Lung CA	Colon CA	Heart Attack	High Cholesterol	Asthma	Write in (Liver Disease, Kidney Disease, Dialysis, Kidney Stones, Clotting, Blood disorders, bleeding issues etc)
Mother									
Father									
Sister									
Brother									
Grandmother									
Grandfather									

Social History

Alcohol Use	[ ] Yes [ ] No	
Smoking Status (3+)	[ ] Yes [ ] No	Environmental Exposure [ ] Yes [ ] No
Who lives at home?		
Caffeine	Estimated intake per day (soda, tea, coffee)	
Nutrition & Feeding	Any dietary restrictions?	
	Any foods intentionally avoided?	
	Milk intake, ounces/per day?	
	Was your child Breast fed [ ] No [ ] Yes	

Immunizations

Immunizations Up To Date [ ]	Flu Shot Given (Date):	Denied [ ] Refused [ ]

Review of Systems: - Please check each item YES or NO as they relate to your CHILDS CURRENT HEALTH

		YES NO		YES NO		YES NO
Constitutional	Weight Loss Fatigue	[ ] [ ] [ ] [ ]	Fever	[ ] [ ]	Chills	[ ] [ ]
Dermatology/ Integument	Stria / Stretch mark Rash	[ ] [ ] [ ] [ ]	Lesions Itching	[ ] [ ] [ ] [ ]	Sores	[ ] [ ]
HEENT	Glasses Contacts Vision Changes	[ ] [ ] [ ] [ ] [ ] [ ]	Eye Redness Hearing Problems Double Vision	[ ] [ ] [ ] [ ] [ ] [ ]	Sinus Trouble Nasal Stuffiness Sore Throat	[ ] [ ] [ ] [ ] [ ] [ ]
Resp/Pulmonary	Cough	[ ] [ ]	Wheezing	[ ] [ ]	Snoring	[ ] [ ]

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	Coughing Blood	[] []	Shortness of Breath	[] []		
Cardiology	Murmur Chest Pain Palpitations	[] [] [] [] [] []	Dizziness Fainting Spells Shortness of Breath	[] [] [] [] [] []	Difficulty lying flat Swelling in Ankles	[] [] [] []
Gastroenterology	Nausea Vomiting	[] [] [] []	Abdominal Pain Diarrhea	[] [] [] []	Blood in Stool Dark tarry stool	[] [] [] []
Genital/Urinary	Burning Nighttime Accidents Frequent Urination	[] [] [] [] [] []	Blood in Urine Flank Pain UTI's	[] [] [] [] [] []	Circumcised	[] []
Musculoskeletal	Join Pain Bone Pain	[] [] [] []	Swelling Muscle Pain	[] [] [] []	Fractures	[] []
Neurology	Abnormal Movement	[] []	Normal Development	[] []	Headaches Numbness Seizures	[] [] [] [] [] []
Psychological	Anxiety Depression	[] [] [] []	Mood Swings	[] []	Difficulty Sleeping	[] []
Hem/Lymph	Easy Bruising Gums bleed Easily	[] [] [] []	Enlarged Glands	[] []	Blood Clots	[] []
Endocrinology	Loss of Hair	[] []	Heat/Cold Intolerance	[] []	Other Concerns:	[] []

Signature of Patient/Parent _____

Reviewing Physician _____

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