



**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)**

**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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoking Status (3+)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Environmental Exposure <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes	

**Immunizations**

Immunizations Up To Date <input type="checkbox"/>	Flu Shot Given (Date):	Denied <input type="checkbox"/> Refused <input type="checkbox"/>
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**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	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>
Dermatology/ Integument	Stria / Stretch mark Rash	<input type="checkbox"/>	<input type="checkbox"/>	Lesions Itching	<input type="checkbox"/>	<input type="checkbox"/>	Sores	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Eye Redness	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
	Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Stuffiness	<input type="checkbox"/>	<input type="checkbox"/>
	Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Resp/Pulmonary	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>

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

Signature of Patient/Parent \_\_\_\_\_

Reviewing Physician \_\_\_\_\_