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| Patient Information |
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|  |  |   |  |  |  |
| Child’s Name |  | Date of Birth |  Date of Visit |
|  |  |  |
| Name of Guardian/Parent Completing this form |  | Primary Healthcare Provider’s Name |
|  |  |  |
| Primary concern I would like addressed in today’s visit |  | Secondary concern I would like addressed in today’s visit |
| Medication |
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| --- | --- | --- |
| Medication Name | Dose | Frequency |
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**Please list any allergies to medication or food and their reactions: Check here if none known food or drug allergies** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Review of Systems |

**\*Please check symptoms your child has experienced IN THE LAST 2 WEEKS**

**GENERAL: Check here if none apply**

Abnormal weight loss

Abnormal weight gain

Fever

**EYES AND VISION: Check here if none apply**

Sensitivity to light

Glasses or contacts

Vision changes

**EARS, NOSE, THROAT: Check here if none apply**

Hearing loss

Allergy/runny nose

Difficulty with swallowing

**HEART AND CARDIOVASCULAR:** **Check here if none apply**

Chest pain

Palpitations/heart racing

Fainting

**RESPIRATORY:** **Check here if none apply**

Frequent coughing

Wheezing

Cough with exercise

Nighttime cough

**DEVELOPMENT:** **Check here if none apply**

Speech Delay

Motor Delay

Social Delay

**GASTROINTESTINAL:** **Check here if none apply**

Appetite increase

Appetite decrease

Nausea or vomiting

Frequent diarrhea

Constipation

Stomach pain

**GENITOURINARY: Check here if none apply**

Frequent urination

Painful urination

Daytime Urinary Accidents

Bedwetting

**MUSCULOSKELETAL:** **Check here if none apply**

Pain in multiple joints

Back pain

**\*please turn over and complete the back**

**SKIN:** **Check here if none apply**

Change in hair or nails

Birthmarks

**REPRODUCTIVE: Check here if none apply**

Breast lumps

Breast tenderness

Date of last menstrual period (for females)\_\_\_\_\_\_\_\_\_\_\_\_

**NEUROLOGICAL:** **Check here if none apply**

Frequent headaches

Recurrent headaches

Lightheaded or dizziness

Seizures

Staring spells

Head injury/loss of consciousness

**PSYCHIATRIC:** **Check here if none apply**

Nervousness/anxiety

Depression

Suicidal thoughts

Poor eye contact

Repetitive movements or behaviors

Aggressive behaviors

**ENDOCRINE:** **Check here if none apply**

Concerns about growth

**HEMATOLOGY/LYMPHATIC:** **Check here if none apply**

Anemia

 pale skin

Abnormal lead level

Level has never been checked

**SLEEP:** **Check here if none apply**

Loud snoring

Difficulty falling sleep

Difficulty staying asleep

Not rested in the morning

Pauses in breathing at night

Nightmares

Night Terrors

Sleep walking

Sleep talking

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| Interval History |

**\*Returning Patients-**

**Please provide only updates since last visit**

**Has your child received care at any of the following since last visit? (Circle)**

**Primary Care ER/Urgent Care Hospital**

**If yes, list date/reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**New Medical History (include any illnesses such as asthma, diabetes, allergies, GERD, heart problems, surgeries):**

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**Education/Services/Therapy/Testing/Individualized Education Plan (IEP):**

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**New Family History (for example, mental health, learning disability, ADHD, cardiac death):**

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**Social History (any changes at home, parent job changes, school changes, new siblings)**

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| General Health Screening Questions |

**Has your child had a flu shot since 9/1/2018? (circle one)**

Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes, what was the approximate date of the flu shot?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If no, are you interested in learning how your child can get their flu shot today at one of the OUHSC Flu Clinics located elsewhere on campus? (circle one)**

Yes No

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**Does anyone smoke inside or outside your home? (circle one)**

Yes No

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