

Patient Name: _____
 Date of Birth _____
 MRN: _____
 Date: _____

Growth and Development

Up to date _____ NO YES
 Developmental delay, _____ NO YES
 Speech difficulty, _____ NO YES
 Physical limitation _____ NO YES

Immunization History:

Up to Date _____ NO YES

Does patient have any? Yes (circle) No

Does patient have any?	Yes (circle)	No
Fever, Wt loss, decrease appetite		
Pink eye, decrease vision, deafness		
Sore throat; mouth ulcers, baldness		
Rapid heart beat, chest pain		
Shortness of breath, cough		
Nausea/vomiting/Diarrhea, abd pain		
Urinary frequency, urgency, burning, dysuria, flank pain, bed wetting		
Limp, joint pain, swelling, limitation of motion, tenderness		
Rash, scar, birth mark		
Change in sensorium, lethargy		
Allergies, sinusitis, facial swelling		

Birth History

Born Full term _____ premature (weeks) _____
 Normal _____ C section _____
 Birth Weight _____ lb _____ oz
 Complications _____

Past History: (if yes, When?)

Kidney problem: _____ NO YES
 Surgeries: _____ NO YES
 Injuries: _____ NO YES
 Urinary tract Infections: _____ NO YES
 Hospitalization _____ NO YES
 Any medical problem? _____

Medications:

- _____
- _____
- _____
- _____

Allergies:

- Medication _____
- Food _____

Family History: (circle the positive history)

High blood pressure Diabetes Kidney failure
 Dialysis Kidney stone Hearing Loss
 Lupus Psoriasis Crohn disease
 Rheumatoid arthritis Chronic pain Vision loss
 Blood in urine Over weight

Primary Care Physician information

Name _____
 Address _____

 Phone: _____
 Fax: _____

Social History:

Living with parents _____ NO YES
 Pets at home _____ NO YES
 Day Care _____ NO YES
 Sick contact _____ NO YES
 Smoking _____ NO YES
 Drug/Alcohol Use _____ NO YES
 Sexual Activity _____ NO YES
 School grade: _____ Performance: _____