NEW / WELL PEDIATRIC PATIENT – 5 THROUGH 10 YEARS

Name:________________________ Date of Birth:______________

Sex: Male☐ Female☐ Today's Date:_____________________

Accompanying Adult's Name/Relation:____________________________

Please tell us the **REASON FOR TODAY'S VISIT**:

____

____

Please list your child's **CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS:**

Name	Dosage (i.e., MG)	How Taken (i.e., 1 tablet daily)

Please list any ALLERGIES to medications/foods:

Allergy	Type of Reaction (i.e., rash, nausea)

Are **IMMUNIZATIONS** up to date? Yes☐ No☐

IMMUNIZATION PREFERENCE (circle one): **Traditional** ☐ **Delayed** ☐ **None** ☐

INTERVAL HISTORY: *Complete for Children Ages 5 through 8 Years ONLY*

Nutritional Detail:

Solids:
Child's diet is best described as: ☐ Adequate varied diet ☐ Excess junk food

Liquids:
Does your child drink:
☐ Milk _____oz/serving
☐ Juice _____ oz/serving
☐ Water _____oz/serving

Elimination Habits – Bladder:

Any concerns about child's bladder or kidney health? ☐Yes ☐No
Number of wet diapers per day: _____ times/day
Urine color: _________________
Urine stream:_________________
Does child have problem holding urine during the day? ☐Yes ☐No
Does child have problem wetting the bed at night? ☐Yes ☐No

For Nurse Use Only: Ht.____ Wt.____ Temp.____ BP.____ Pulse____ Resp._____ SPO2____ VS; R____L____

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DEVELOPMENTAL HISTORY: Complete for Children Age 5 ONLY

Does/Can your child?	Yes	No	Does/Can your child?	Yes	No
Count 5 objects	☐	☐	Pretend plays	☐	☐
Counts to 10	☐	☐	Prints name	☐	☐
Draws people with 2-5 parts	☐	☐	Rides bike w/training wheels	☐	☐
Follows directions	☐	☐	Skips	☐	☐
Knows address/phone numbers	☐	☐	Speaks understandably	☐	☐
Knows on/off, and over/under	☐	☐	Tells imaginary stories	☐	☐
Plays cooperatively	☐	☐			

Please provide your child's **PAST MEDICAL HISTORY:**

- ☐ ADD/ADHD
- ☐ Abdominal Pain
- ☐ Acne
- ☐ Allergic Rhinitis
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchiolitis
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Concussion, CHI
- ☐ Congenial heart disease
- ☐ Constipation
- ☐ Diabetes
- ☐ Eczema
- ☐ Fracture
- ☐ GERD (reflux)
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart murmur
- ☐ Menstrual problems
- ☐ Migraines
- ☐ Pneumonia
- ☐ Prematurity
- ☐ Pyelonephritis
- ☐ Recurrent otitis media
- ☐ Seizure disorder
- ☐ Seizures - febrile
- ☐ UTI
- ☐ Vesicoureteral reflux
- ☐ ____________: other

Please tell us about any **SURGERIES** your child has had, you may indicate the **date/year if known:**

- ☐ Appendectomy
- ☐ Inguinal Hernia Repair
- ☐ Fracture with Small Reduction
- ☐ Dental Surgery
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ PET placement
- ☐ Lymph node biopsy/excision
- ☐ Umbilical Hernia Repair
- ☐ Hernia repair
- ☐ ______: other

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY**:

Please provide age-appropriate **SOCIAL HISTORY:**

Primary Residence:

Who lives with your child?__________________

____

Tobacco Exposure:

Are there smokers at home? ☐ Yes ☐ No

If yes, do they smoke outside only? ☐ Yes ☐ No

Home Environment:

What is the age of the home: ____________

Is there lead in the home? ☐ Yes ☐ No

Spiritual belief/Religion________________

Education:

School Name: ________________________

School Grade: ________________________

Does child have any learning disabilities?

____

Does child have any special needs?

Child Care:

Who provides care for your child?	**#days/wk:**
☐ Mother	_____days/wk.
☐ Father	_____days/wk.
☐ Grandparent	_____days/wk.
☐ Other: ___________	_____days/wk.
☐ Day Care	_____days/wk.

Sleep:

Does child get 8.5 hrs. of sleep? ☐ Yes ☐ No

Does child have sleeping problems? ☐ Yes ☐ No

Does child take naps? ☐ Yes ☐ No

Does child sleep with parents? ☐ Yes ☐ No

Does child sleep through the night? ☐ Yes ☐ No

What position does child sleep in?_____________

Safety:

Do you use a car seat? ☐ Yes ☐ No

If yes, is car seat facing: ☐ Front ☐ Rear

Is there a carbon monoxide detector? ☐ Yes ☐ No

Are smoke detectors in the home? ☐ Yes ☐ No

Please provide your child's **PAST MEDICAL HISTORY** & **SURGICAL HISTORY** date/year if known:

____

____

Please provide your child's **FAMILY HISTORY:**

FATHER: ☐ Alive ☐ Deceased Age ________ Reason Deceased? ____________
Health Problems ______________________________________

MOTHER: ☐ Alive ☐ Deceased Age ________ Reason Deceased? ____________
Health Problems ______________________________________

BROTHERS AND SISTERS: (Each one: Are they living? Reason Deceased? Ages? Other health problems?)

____
____
____

OTHER: (NAMES AND AGES, Are they living? Reason Deceased? Ages? Other health problems?)

____
____
____

Does anyone in the family have these health conditions? (Please check even if listed above)

___☐___ Heart Problems (Heart Attacks, Heart Failure)
___☐___ Breast Cancer
___☐___ Colon Cancer
___☐___ Prostate Cancer
___☐___ Skin Cancer
___☐___ Diabetes
___☐___ Strokes
___☐___ Mood Disorders (Anxiety, Depression, Bipolar, etc.)

HEALTH MAINTENANCE: (Please list Date)

Last Dental Appointment:___________________________________
Last Eye Doctor Appointment:________________________________

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

PHYSICIAN REVIEWED: ___________________________________ **DATE:** ______________