PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date ____/____/____ Date of Last Physical Exam _____/_____/____

Last Name _____ First Name _____ Middle _____
Medical Record Number _____ Date of Birth _____

Chief Complaint

What is the main reason for your child's visit today?? (Describe your child's problem in detail)

_____
_____
_____

History of Present Illness

Please answer the following questions

Location of problem
Abdomen Back Bladder
Other_____
_____
_____

On a scale of 1-10, with 10 being the most severe,
Circle the number that best describes the problem??

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem??
7 Days ago 2 weeks ago 1 month ago
Other_____
Does anything help or make the problem worse??
_____
_____

How long does the problem last??
30 minutes 1 hour Always there
Other_____

Is anything else occurring at the same time??
Yes No If yes, please explain.
Vomiting/Diarrhea Fever Blood in urine
Other_____

Is the problem constant or variable??
Always there Sometimes there, sometimes not
Other_____

Does the problem interfere with your child's Normal functions??
Yes No If Yes, please explain_____
_____

Are child's immunizations current Yes No

Physician's use only (Comments/Notes)

= L 1-3 = 1-2 >4 = 3-5

Past Medical, Family, & Social History

List all serious illnesses in your immediate family (Example: Diabetes, Kidney failure, Dialysis, Kidney transplant, ect.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any of your child's past illness and/or Surgeries and when they occurred.
Dates of Surgery Date
_____
_____
_____

Is your child on any medication?? Y N (If yes, list all)
_____ _____
_____ _____
Is your child on a special diet?? Y N (If yes, please explain)
_____ _____
Does your child have any allergies?? Y N (If yes, please explain)
_____ _____

Physician use only:

= L 0 = 1-2 1-2 = 3

Review of Systems

Does your child now or has he/she had any recent problems related to the following systems?? Circle Yes or NO. Please explain any Yes answer in space provided.

General

Fever Y N
Chills Y N
Abnormal growth Y N
Abnormal development Y N
Other _____

Eyes

Blurred vision Y N
Redness Y N
Pain Y N
Other _____

Allergies

Hay fever Y N
Drug allergies Y N
Foods Y N
Other _____

Nervous system

Seizures Y N
Abnormal walking Y N
Abnormal coordination Y N
Other _____

Hormone system

Excessive thirst Y N
Tired/sluggish Y N
Abnormal hair growth Y N
Other _____

Stomach/intestines

Stomach pain Y N
Nausea/vomiting Y N
Constipation Y N
Other_____

Heart

Heart murmur Y N
High blood pressure Y N
Other _____

Skin

Rashes Y N
Continued itching Y N
Easy bruising Y N
Other _____

Muscle system

Joint pain Y N
Back pain Y N
Muscle cramping Y N
Other _____

Ear/Nose/Throat/Mouth

Ear infections Y N
Sore throat Y N
Sinus problems Y N
Other _____

Kidney/Bladder

Blood in urine Y N
Burning with urination Y N
Frequent urination Y N
Other_____

Lungs

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other _____

Blood/Lymph glands

Swollen glands Y N
Blood clotting problems Y N
Other _____

Physicians Use Only: (Comments)

= L
0-1 = 1-2
2-9 = 3
>10 = 4-5

Physician _____ Date _____/_____/_____