

Office Use Only

VFC: [ ] MDD/DKC  
[ ] Native  
[ ] NO Insurance  
[ ] Not Eligible

INSURANCE Notes



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WT: \_\_\_\_\_ lb  
\_\_\_\_\_ kg  
Temp: \_\_\_\_\_  
Pain Scale: \_\_\_\_\_

Child's name:

\_\_\_\_\_

Child's birthday:

\_\_\_\_\_

Reason for visit:

\_\_\_\_\_

Symptoms:

Fever yes/no. If yes, how long? \_\_\_\_\_  
Earache yes/no. If yes, how long? \_\_\_\_\_  
Ear discharge yes/no. If yes, how long? \_\_\_\_\_  
Pulling at ears yes/no. If yes, how long? \_\_\_\_\_  
Nasal discharge yes/no. If yes, how long? \_\_\_\_\_  
Congestion yes/no. If yes, how long? \_\_\_\_\_  
Sore throat yes/no. If yes, how long? \_\_\_\_\_  
Cough yes/no. If yes, how long? \_\_\_\_\_

Other symptoms:

Decreased appetite yes/no. If yes, how long? \_\_\_\_\_  
Vomiting yes/no. If yes, how long? \_\_\_\_\_  
Abdominal pain yes/no. If yes, how long? \_\_\_\_\_  
Diarrhea yes/no. If yes, how long? \_\_\_\_\_  
Rash yes/no. If yes, how long? \_\_\_\_\_

Does your child have any chronic medical problems? Yes/no. If yes, please explain. \_\_\_\_\_

Is your child taking any daily prescribed medications? Yes/no. If yes, please explain. \_\_\_\_\_

Is your child taking over-the-counter cold medications? Yes/no. Motrin or Tylenol? Yes/no.

Does your child have a medication allergy? Yes/no. What medication/reaction? \_\_\_\_\_

Has your child been admitted to the hospital overnight? Yes/no. If yes, please explain. \_\_\_\_\_

Does your family have any pets? Yes/no please circle: dog/cat/other \_\_\_\_\_

Has your child been exposed to someone with similar symptoms? Yes/no, who? \_\_\_\_\_

Has your child had any surgeries? Yes/no. If yes, please explain. \_\_\_\_\_

Does anyone in the family have:

Asthma? Yes/no please circle: father/mother/sibling

Seasonal allergies? Yes/no please circle: father/mother/sibling

Does anyone in the family smoke? Yes/no.

Does your child attend daycare/preschool/school? (please circle) What grade in school? \_\_\_\_\_

Are your child's immunizations up-to-date? Yes/no If no, please explain. \_\_\_\_\_

Does your child have ear tubes? Yes/no. When were they placed? \_\_\_\_\_

This form completed by: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_