

Office Use Only

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



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WT: _____ lb
_____ kg
Temp: _____
Pain Scale: _____
Vision > 4 years old

Child's name: _____

Child's birthday: _____

Reason for visit: _____

Symptoms:

Fever yes/no. If yes, how long? _____
Eye discharge yes/no. If yes, how long? _____
Red eyes yes/no. If yes, how long? _____
Earache 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? _____
Cough yes/no. If yes, how long? _____

Other symptoms:

Headache yes/no. If yes, how long? _____
Eyesight problems yes/no. If yes, how long? _____
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. _____

This form completed by: _____ Relationship to Child: _____