

Office Use Only

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



# General Follow-up / Routine Visit

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

Child's name: \_\_\_\_\_

Child's birthday: \_\_\_\_\_

What is your concern today regarding your child? \_\_\_\_\_

## Symptoms

Fever	yes/no. If yes, how long?	_____
Headache	yes/no. If yes, how long?	_____
Ear pain/Ear pulling	yes/no. If yes, how long?	_____
Neck pain	yes/no. If yes, how long?	_____
Chest pain	yes/no. If yes, how long?	_____
Cough	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?	_____
Urinary symptoms	yes/no. If yes, how long?	_____
Rash	yes/no. If yes, how long?	_____
Joint pain	yes/no. If yes, how long?	_____
Sleep problems	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. \_\_\_\_\_

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: \_\_\_\_\_