

Office Use Only

- VFC: MDD/DKC
- Native
- NO Insurance
- Not Eligible

INSURANCE Notes



Office Use Only

- WT: _____ lb
- _____ kg
- Temp: _____
- Pain Scale: _____

Child's name: _____

Child's birthday: _____

Does your child prefer liquid or pills? _____

Reason for visit: _____

Symptoms

- Fever yes/no. If yes, how long? _____
- Nasal discharge yes/no. If yes, how long? _____
- Nasal congestion yes/no. If yes, how long? _____
- Cough yes/no. If yes, how long? _____
- Hoarseness yes/no. If yes, how long? _____
- Sore throat yes/no. If yes, how long? _____
- Choking on food yes/no. If yes, how long? _____
- Sores in mouth yes/no. If yes, how long? _____
- Difficulty swallowing yes/no. If yes, how long? _____
- Rash yes/no. If yes, how long? _____
- Lymph node swelling yes/no. If yes, how long? _____

Other symptoms

- Headache yes/no. If yes, how long? _____
- Eye discharge yes/no. If yes, how long? _____
- Earache/ear pulling? 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? _____
- Myalgias (muscle pain) 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 any 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: _____