

*Office Use Only*WT: \_\_\_\_\_\_kg \_\_\_\_\_\_ lb

HT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen: \_\_\_\_\_\_\_\_\_\_\_\_\_

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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VFC: [ ] V02 -- MDD

 [ ] V03 -- No Ins

 [ ] V04 -- Native

 [ ] V07 – AVAP

INSURANCE:

 Copay / Co-ins

Statement Balance

**Pink Eye / Eye Pain / Ear Pain**

**Is this a follow-up appointment? Yes / No.**

**Child’s name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Child’s birthday:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your child’s primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**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? \_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_

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 a medication allergy? Yes/no. What medication/reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Has your child had any surgeries? 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. If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Motrin or Tylenol? Yes/No

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

Does anyone in the family have:

Asthma ? Yes/no please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seasonal allergies? Yes/no please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets? Yes / No. Which kind/how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**