Office Use Only

VFC: [ ] V02 -- MDD
[ ] V03 -- No Ins
[ ] V04 -- Native
[ ] V07 – AVAP
INSURANCE:
Copay / Co-ins

Statement Balance

Rash / Skin Irritation

Office Use Only

WT: ______kg ______ lb
HT: _________________
Temp: _______________
Resp: _______________
Pulse: _______________
Oxygen: _____________
BP: _________________

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

Child's name: ______________________________ **Child's birthday:** ______________________

Who is your child's primary care physician? ______________________________

Please describe your child's rash: ______________________________

Symptoms:

Fever	yes/no. If yes, how long?	___________
Swollen glands	yes/no. If yes, how long?	___________
Itching / Scratching	yes/no. If yes, how long?	___________
Cough / Runny Nose	yes/no. If yes, how long?	___________
Vomiting	yes/no. If yes, how long?	___________
Diarrhea	yes/no. If yes, how long?	___________
Abdominal pain	yes/no. If yes, how long?	___________
Joint pain or swelling	yes/no. If yes, how long?	___________

For Girls Only if Applicable

Last menstrual period was: _________________

Periods started at age:______________________

Any problems?__________________________
____

Questions:

When was the rash first noticed? ______________________________

Within a few days of noticing the rash, did you or your child:

Change laundry detergents, lotions, or soaps?	Yes / No	List: ______________________
Wear any new, unwashed clothes?	Yes / No	
Hike in the woods?	Yes / No	
Been in a pool, hot tub, or outdoor body of water?	Yes / No	Describe: ______________________
Travel?	Yes / No	Where? ______________________
Eat anything new?	Yes / No	Describe: ______________________
Take any new medications or prescriptions?	Yes / No	Describe: ______________________
Had exposure to anyone with scabies/bed bugs/lice?	Yes / No	Describe: ______________________

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: ______________________
Eczema?	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**__________________

Updated: 10/12/16