

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

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

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

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

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

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

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

*Office Use Only*

VFC: [ ] V02 -- MDD

 [ ] V03 -- No Ins

 [ ] V04 -- Native

 [ ] V07 -- AVAP

INSURANCE:

 Copay / Co-ins

Statement Balance

**Urinary Symptoms**

**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**

|  |
| --- |
| ***For Girls Only if Applicable***Last menstrual period was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Periods started at age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

Abdominal pain yes/no. If yes, how long? \_\_\_\_\_\_\_

Urinary “accidents”? yes/no

Blood in urine? yes/no. If yes, how long?\_\_\_\_\_\_\_

Urgency urination? yes/no.

Frequent urination? yes/no.

Bedwetting? yes/no.

Painful urination? yes/no

Does your child’s urine have a smelly odor? yes/no.

How much water does your child drink daily? \_\_\_\_\_\_\_\_\_\_\_\_

**Review of systems**:

Fever yes/no. If yes, how long? \_\_\_\_\_\_ Dry skin yes/no. If yes, how long? \_\_\_\_\_\_

Decreased appetite yes/no. If yes, how long? \_\_\_\_\_\_ Rash yes/no. If yes, how long? \_\_\_\_\_\_

Heartburn yes/no. If yes, how long? \_\_\_\_\_\_ Joint pain yes/no. If yes, how long? \_\_\_\_\_\_

Vomiting yes/no. If yes, how long? \_\_\_\_\_\_ Sleep problems yes/no. If yes, how long? \_\_\_\_\_\_

Diarrhea yes/no. If yes, how long? \_\_\_\_\_\_ Is your child potty trained? Yes / No / Attempting

Does your child have frequent UTI’s? yes/no. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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/school? (please circle) Where do they attend/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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**