Comprehensive New Patient Assessment – Child – page 1

Child's name		Age	Date of Birth	Today's Date
Child's parents:	☐ Married ☐ Divorced ☐ Separated ☐ Never married	If parents are not married, who has custody?	Name of person filling out this form	

FATHER		MOTHER	
Name	Age	Name	Age
Street address		Street address	
City/state/zip		City/state/zip	
Type of work		Type of work	
Employer		Employer	
Home phone	Work phone	Home phone	Work phone

Who lives in the same household as your child?

CHIEF COMPLAINT

Briefly describe your child's main medical problem(s), if any.

FAMILY HISTORY List all of your child's immediate family members. List all known medical problems of each (including cause of death if appropriate). Be sure to include:

Diabetes	Heart disease	Learning disabled	High blood pressure
Asthma	Lead poisoning	Cystic fibrosis	Failure to thrive
Sickle cell anemia/trait	Allergies	Bleeding disorders	Anemia
Lung disorders	Deafness	Tuberculosis	Hepatitis
HIV/Aids	Genetic disorders	Birth defects	Cancer (list type)
Leukemia	Depression	Mental disorders	Epilepsy or seizures
Muscle disorders	Migraine headaches	Kidney disease	

	Name			Alive?	Age now or at time of death	Medical problems (including cause of death if appropriate)
Mother						
Father						
Brothers and Sisters (✓full or half)		Full	Half			

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EDUCATIONAL HISTORY

Name of child's school	Grade	Classroom assignment:	☐ Regular class ☐ Accelerated class ☐ Learning disabled class

Does your child have **significant** problems with his/her classroom behavior or attention span?	☐ Yes ☐ No	If yes, explain:
Do your child's medical problems affect his/her school activities?	☐ Yes ☐ No	If yes, explain:

HEALTH RISK ASSESSMENT

Is your child exposed to tobacco smoke in the home?	☐ Yes ☐ No	If yes, explain:
Is your child exposed to excessive alcohol consumption in the home?	☐ Yes ☐ No	If yes, explain:

Does your child always wear a seatbelt/shoulder harness or ride in a car seat when you drive?	☐ Yes ☐ No	Does your child always wear a helmet when he/she roller skates, skateboards, or rides a bicycle?	☐ Yes ☐ No	Does your child ever ride in the bed of a pickup truck?	☐ Yes ☐ No

IMMUNIZATION HISTORY **You must provide documentation of immunizations.**

CHICKEN POX	☐ Had chicken pox ☐ Had the chicken pox vaccine 1. _____ date 2. _____ date (2nd dose needed only if 1st dose given after age 13)
DPT (diphtheria, pertussis, tetanus)	1. _____ date 2. _____ date 3. _____ date 4. _____ date 5. _____ date
TETANUS BOOSTER	Required every 10 years after age 5 **or** within 5 years of a skin injury. _____ date
POLIO	1. _____ date 2. _____ date 3. _____ date 4. _____ date 5. _____ date (4 doses are required)
MMR (measles, mumps rubella)	1. _____ date 2. _____ date
HEPATITIS B	1. _____ date 2. _____ date 3. _____ date
HAEMOPHILUS TYPE B	1. _____ date 2. _____ date 3. _____ date 4. _____ date
FLU	Recommended yearly for children with asthma or other respiratory problems, heart disease, diabetes, immune deficiency, kidney disease, or other chronic medical conditions. ☐ I want my child to get flu shots
ROTA VIRUS	Being released in 1998. Dr. Manley will discuss this if it is approved and proves to be safe.

DIET HISTORY

Does your child eat/ drink:	☐ fruits	☐ juices	☐ milk	☐ too many soft drinks
	☐ cheese	☐ meats	☐ potatoes	☐ green vegetables
	☐ yellow vegetables	☐ cereal	☐ milk (How many glasses per day? _____)	
	☐ too many sweets/desserts		☐ water (How many glasses per day? _____)	

Is your home supplied with city water or well water?	If well water, has the fluoride level been checked?
My child is on the following special diet:	

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CHRONIC DISEASES List all of your child's known chronic medical conditions or diseases

Disease or condition	Age at diagnosis	Current status	If your child sees a specialist, who is it?

SURGERIES List all of your child's major surgeries

Type of surgery	Where done	Age or year	Surgeon's name

HOSPITALIZATIONS List all major hospitalizations other than for chronic diseases/conditions or for surgeries listed above

Reason for hospitalization	Age or year	Treating physician

ALLERGIES List all drug, food, or other allergies your child has

Drugs your child is allergic to or make him/her sick	What happens if he/she takes it?	Foods your child is allergic to	Other things your child is allergic to

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REVIEW OF SYSTEMS	Check all of the following symptoms that your child **now has:**			
GENERAL/ CONSTITUTIONAL	☐ fever ☐ excessive fatigue	☐ unintended weight loss ☐ failure to thrive	☐ unintended weight gain ☐ nightmares	☐ birth defects ☐ other _____
SKIN	☐ itching ☐ hives ☐ corns ☐ growth you want removed ☐ eczema	☐ burning ☐ fungus ☐ ingrown nail ☐ discolored/irregular mole ☐ thumb sucking past age 2	☐ mole you want removed ☐ warts ☐ skin tumor/growth ☐ mole that has changed	☐ acne ☐ chronic skin problem ☐ sores ☐ other _____
EAR	☐ hearing loss ☐ pain	☐ recurrent ear aches/infections ☐ drainage	☐ noises in the ear	☐ motion sickness ☐ other _____
NOSE	☐ sinus pain or pressure ☐ recurrent sinus infections	☐ nose bleeds	☐ loss of smell	☐ chronic nasal drainage ☐ other _____
MOUTH/THROAT	☐ sore tongue ☐ recurrent sore throat ☐ cavities	☐ bleeding gums ☐ recurrent mouth ulcers ☐ tooth pain	☐ hoarseness ☐ thrush/white patches ☐ recurrent strept throat	☐ mumps ☐ peculiar taste ☐ other _____
EYES	☐ wear glasses/contacts ☐ excessive tearing ☐ color blind	☐ blurry vision ☐ drainage	☐ double vision ☐ burning ☐ dryness	☐ glaucoma ☐ redness ☐ other _____
HEART/CIRCULATION	☐ chest pain ☐ legs/arms get cold ☐ rheumatic fever	☐ high blood pressure ☐ palpitations/heart pounding ☐ fingers turn blue, white or red	☐ irregular heart beat ☐ need to take antibiotics before dental procedures	☐ heart murmur ☐ poor circulation ☐ scarlet fever ☐ other _____
LUNGS	☐ chronic cough ☐ always short of breath ☐ asthma	☐ wheezing ☐ tuberculosis	☐ cough up blood ☐ short of breath with mild exercise	☐ cough up sputum/phlegm ☐ pneumonia ☐ other _____
DIGESTIVE	☐ loss of appetite ☐ bloating ☐ vomiting blood ☐ trouble swallowing	☐ nausea ☐ liver disease ☐ blood, mucous, puss in stools ☐ stools in pants	☐ vomiting ☐ ulcers ☐ abdominal pain	☐ diarrhea ☐ change in bowel habits ☐ constipation ☐ other _____
URINARY	☐ bed wetting ☐ blood in urine	☐ inability to hold urine ☐ pain/burning with urination	☐ urine/bladder/kidney infection	☐ leak urine ☐ other _____
NERVOUS	☐ seizures/convulsions ☐ temporary blindness ☐ paralysis	☐ numbness ☐ weakness of extremity ☐ polio	☐ fainting spells ☐ dizzy spells ☐ meningitis	☐ severe headaches ☐ stroke ☐ other _____
MUSCULOSKELETAL	☐ painful joints ☐ arthritis	☐ muscle pain	☐ swollen joints	☐ back pain ☐ other _____
GLANDS	☐ very sensitive to temperature changes ☐ excessive fluid intake	☐ hair loss ☐ thinning/coarsening of hair	☐ thyroid disorder ☐ frequent urination	☐ diabetes ☐ constantly thirsty ☐ other _____
MENTAL	☐ depressed ☐ suicidal thoughts ☐ unable to concentrate	☐ excessive worry ☐ hear voices ☐ cry too much	☐ excessive anger ☐ memory problems ☐ unhappy	☐ sleep problems ☐ sleep too much ☐ other _____
BLOOD/LYMPH	☐ anemia	☐ swollen lymph nodes	☐ bleed easily	☐ easy bruising ☐ other _____
ALLERGY/IMMUNITY	☐ hay fever	☐ allergies	☐ immune deficiency	☐ HIV/AIDS ☐ other _____
GENITAL/SEXUAL	☐ undescended testicle	☐ vaginal discharge/bleeding		☐ other _____

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BIRTH/NEWBORN/NEONATAL HISTORY Skip this section if your child is over 2 years old.

Mother's age when this child was born	Total number of pregnancies of mother	Total number of deliveries of mother	Number of miscarriages of mother	Number of abortions of mother
Was this a premature birth?	If yes, how many weeks?	Was this birth by C-section?	Which pregnancy was this child?	Birth weight
Length of labor	Was this a breach delivery?	Breast or bottle feed	If breast feed, for how long?	Was this a multiple birth?

Mother's health during this pregnancy

- ☐ high blood pressure
- ☐ rubella (German measles)
- ☐ drug use
- ☐ syphilis
- ☐ group B strept infection
- ☐ diabetes
- ☐ excessive weight gain
- ☐ bladder or kidney infection
- ☐ gonorrhea
- ☐ toxemia/preeclampsia/eclampsia
- ☐ alcohol use _____ drinks per day
- ☐ smoked _____ packs per day
- ☐ chlamydia
- ☐ other _____

List any other problems during pregnancy, labor, or delivery

CURRENT MEDICATIONS List all current medications, *including over the counter medicines and vitamins/supplements*, your child routinely takes. Also list all medications your child takes only on an as needed basis.

Name of medication	Dosage (milligrams)	How taken (times per day, with food, at bedtime, etc.)	This space for as needed medications only: why taken and how often actually used?

DOCTOR'S NOTES

REVIEWED

Signature of doctor	Date	Signature of doctor	Date	Signature of doctor	Date