

Today's Date: _____ Patient's Name: _____ Date of Birth _____
(last, first and middle) (month, day, year)

Primary Care Doctor: _____ Age _____

Why are you here today?

Specialists my child sees:

PAST MEDICAL HISTORY – TRANSLATED BY: _____ **INTERPRETED BY:** _____ **FROM SPECTRUM HEALTH**

List your child's medical diagnoses	List your child's medications & doses
List any previous surgeries & dates	List hospitalizations. Give reason and approximate date

Allergies: No, none known Yes (list medicines & reaction) _____

Latex Allergy Yes No Latex Precautions: Yes No Metal Allergy: Yes No

DIET: Regular Breast Milk Formula _____
(Type of formula/how much per feeding)

Special or other dietary needs – Describe _____

IMMUNIZATIONS: Are they up to date? Yes No Not Sure

BIRTH HISTORY: Birth Weight _____ Premature: Yes No How many weeks early? _____

Did baby need a ventilator? _____ How long? _____ Did baby need supplemental oxygen? _____ How long? _____

Other pregnancy or birth concerns: _____

FAMILY HISTORY: Please indicate if the patients' parents, grandparents, brothers or sisters have had any of the following conditions:

CONDITION	RELATION TO PATIENT	CONDITION	RELATION TO PATIENT	CONDITION	RELATION TO PATIENT
Bleeding Problems <input type="checkbox"/> No <input type="checkbox"/> Yes		Sickle Cell Disease <input type="checkbox"/> No <input type="checkbox"/> Yes		Problems w/ Anesthesia <input type="checkbox"/> No <input type="checkbox"/> Yes	
Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes		Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes		Problems similar to patient's problem <input type="checkbox"/> No <input type="checkbox"/> Yes	
Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes		HIV/Aids <input type="checkbox"/> No <input type="checkbox"/> Yes			

SOCIAL HISTORY: (Check all that apply) Child lives with: Father Mother Siblings (ages) _____

Stepparent Foster parent Grandparents Legal Guardian _____

Smoking in the Household (inside or outside): Yes patient smokes Yes parent, 1 or both smoke No one smokes

TODAY'S DATE _____ PATIENT: _____ DOB: _____ AGE: _____

REVIEW OF SYSTEMS

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Explain yes answers below.

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
BIRTH HISTORY			CARDIAC			HEMATOLOGIC			PSYCHOSOCIAL		
Full Term			Heart Defect			Blood Clots			ADHD		
Premature			Heart Murmur			Bleeding tendencies			Depression		
Apnea/Bradycardia			RESPIRATORY			SKIN			Aspergers		
Required Breathing Tube			Asthma			Rash			Autism		
GASTROINTESTINAL			Lung Disease			Bruises			Anxiety disorders		
Diarrhea			GENITOURINARY			Birthmarks			PLEASE LIST BELOW: Any symptoms/diseases not listed above		
Constipation			Kidney Disease			OPHTHALMIC					
Rectal Bleeding			Urinary Problems			Retinopathy					
Reflux			Urinary Tract Infections			EAR, NOSE & THROAT					
Trouble swallowing			ENDOCRINE/METABOLIC			Loose Teeth					
Nausea			Diabetes			Deafness					
Vomiting			Thyroid Disorders			BREAST					
Abdominal Pain			NEUROLOGIC			Lumps					
MUSCULOSKELETAL			Seizures			Discharge					
Muscle Disease			Cerebral Palsy								

GIVE THE DETAILS OF YOUR YES ANSWERS:

TO BE COMPLETED BY PHYSICIAN

I reviewed the "Review of Systems" with the patient and his/her family, except for those listed here or in HPI, the remaining systems are negative or noncontributory.

I spent 10 min 15 min 25 min 30 min 40 min 60 min 80 min

with patient and/or family in face to face counseling. In _____ Out _____