Office Use Only

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

Statement Balance

Acute Appointment

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

Office Use Only

WT: _____kg _____ lb
HT: _____
Temp: _____
Resp: _____
Pulse: _____
Oxygen: _____
BP: _____

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?	_____
Nasal discharge	yes/no. If yes, how long?	_____
Nasal congestion	yes/no. If yes, how long?	_____
Cough	yes/no. If yes, how long?	_____
Hoarseness	yes/no. If yes, how long?	_____
Sore throat	yes/no. If yes, how long?	_____
Choking on food	yes/no If yes, how long?	_____
Sores in mouth	yes/no. If yes, how long?	_____
Difficulty swallowing	yes/no. If yes, how long?	_____
Rash	yes/no. If yes, how long?	_____
Lymph node swelling	yes/no. If yes, how long?	_____
Headache	yes/no. If yes, how long?	_____
Eye discharge	yes/no If yes, how long?	_____
Earache/ear pulling?	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?	_____
Urinary symptoms	yes/no. If yes, how long?	_____
Muscle aches	yes/no. If yes, how long?	_____
Sleep problems	yes/no. If yes, how long?	_____

For Girls Only if Applicable

Last menstrual period was: _____

Periods started at age:_____

Any problems?_____
_____

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/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**_____

Updated: 10/12/16