Patient Label

## PEDIATRIC INITIAL HISTORY AND PHYSICAL

**Today's Date:** _____ / _____/ _____ **Age:** _____ **Family Doctor:** _____ ☐**LEP: Interpreter** _____

## PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE PATIENT:

What is the main reason for the patient's visit today?

Is the patient having any problems or symptoms today that you would like to discuss? ❑ yes ❑ no
If you answered yes, please briefly explain:

Is the patient allergic to any medicines or foods? ❑ yes ❑ no
If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:

Patient's current medications (*Prescription / Over the counter)*: ❑ None ❑ Multivitamins ❑ Folic Acid ❑ Calcium ❑ Birth Control ❑ Other:

Has the patient had any hospitalizations, major injuries, or surgeries? ❑ yes ❑ no
If you answered yes, please briefly explain:

Patient's Living Conditions: ❑ Alone ❑ With family: # of children in home_____ ❑ With Roommate ❑ In group or foster home

Patient's Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Patient's Education: ❑ Not a student.
Highest education level completed: _____
❑ Current Student:
School _____Grade_____
❑ Daycare: Where? _____

Patient's Employment: ❑ Not employed
❑ Currently employed: Where?
_____

**Please check if the patient <u>has or had</u> any of the following:** ❑ **NO CURRENT COMPLAINTS**

**CONSTITUTIONAL**
- ❑ Fatigue
- ❑ Difficulty sleeping
- ❑ Fever/chills
- ❑ Night sweats
- ❑ Recent weight change

**EYES**
- ❑Blurred or double vision
- ❑Dryness / Redness
- ❑ Wear glasses or contacts
- ❑ Cataracts
- ❑ Glaucoma

**EARS/NOSE/MOUTH/THROAT**
- ❑Earaches or drainage
- ❑Ringing in the ears
- ❑Hearing loss
- ❑Sinus infections/problems
- ❑Nosebleeds
- ❑Frequent sore throat
- ❑Dryness of the mouth
- ❑Bad breath/bad taste
- ❑Mouth sores/ulcers
- ❑Voice changes
- ❑Bleeding gums
- ❑Difficulty swallowing
- ❑Dentures

**HEAD, FACE, NECK**
- ❑ Headaches
- ❑ Reduced facial strength
- ❑ Recent hair loss
- ❑ Scalp tenderness
- ❑ Swollen glands in the neck

**CHEST/BREAST**
- ❑ Breast discharge
- ❑ Breast lump
- ❑ Breast pain
- ❑ Breast implants

**GASTROINTESTINAL**
- ❑ Heartburn or indigestion
- ❑ Loss of appetite
- ❑ Abdominal pain
- ❑ Changes in bowel habits
- ❑ Painful bowel movements
- ❑ Constipation
- ❑ Frequent diarrhea
- ❑ Hemorrhoids/blood in stool
- ❑ Nausea or vomiting
- ❑ Abnormal liver tests/ liver disease

**ENDOCRINE**
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Excessive thirst
- ❑ Change in tolerance to hot/cold weather

**CARDIOVASCULAR**
- ❑ Angina or heart attack
- ❑ Chest pain or pressure
- ❑ Fast or irregular heart beat
- ❑ Swelling of feet / ankles
- ❑ Poor circulation
- ❑ Blood clots
- ❑ High blood pressure

**GENITOURINARY**
- ❑ Burning or painful urination
- ❑ Blood or pus in urine
- ❑ Incontinence or dribbling
- ❑ Vaginal discharge
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Prostate problems
- ❑ Testicular pain
- ❑ Sexual difficulty
- ❑ Genital rash or ulcers

**SKIN**
- ❑ Rash or itching
- ❑ Change in moles
- ❑ Change in skin color
- ❑ Psoriasis
- ❑ Skin nodules or bumps
- ❑ Easy bruising
- ❑ Sores that won't heal

**RESPIRATORY**
- ❑Asthma or Wheezing
- ❑ Difficulty breathing
- ❑ Cough with mucous production
- ❑ Chronic or frequent coughs
- ❑ Dry cough
- ❑ Pain on breathing
- ❑ Spitting/coughing blood

**MUSCULOSKELETAL**
- ❑ Back pain
- ❑ Cold extremities
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Weakness of muscles or joints
- ❑ Walk with assistive device
- ❑ Difficulty climbing stairs

**NEUROLOGICAL / PSYCHIATRIC**
- ❑Convulsions or seizures
- ❑Tremors
- ❑Memory loss or confusion
- ❑Light headed/ Dizziness
- ❑Loss of consciousness
- ❑Stroke
- ❑ Depression

**Please ✓ those that apply to the patient or the patient's blood relatives.**

| | Patient | Parent | Brother/Sister | Grandparent | Child |
|---|---|---|---|---|---|
| HIV/AIDS | | | | | |
| Alcohol / Drug Addiction | | | | | |
| Alzheimer's | | | | | |
| Arthritis | | | | | |
| Asthma | | | | | |
| Birth Defects | | | | | |
| Bleeding Disorder / Free Bleeder | | | | | |
| Cancer | | | | | |
| COPD / Emphysema / Chronic Bronchitis | | | | | |
| Diabetes | | | | | |
| Epilepsy / Convulsions / Seizures | | | | | |
| Heart Attack / Stroke | | | | | |
| High Blood Pressure | | | | | |
| High Cholesterol | | | | | |
| Kidney Disease | | | | | |
| Liver Disease / Hepatitis | | | | | |
| Mental Illness / Depression | | | | | |
| Osteoporosis | | | | | |
| Sickle Cell | | | | | |
| Thyroid Disorder | | | | | |
| Tuberculosis/TB | | | | | |
| Other: | | | | | |

**Please ✓ or describe all that apply.**

**Nutrition: check foods you eat every day**
❑Milk / Dairy ❑Meats ❑Vegetables
❑Fruits ❑Breads or Grains

**Do you have concerns about the patient's weight?**
❑Yes ❑No

**Exercise**
❑ None ❑ Seldom
❑ Occasional ❑ Frequent

**Tobacco Use/ Smoke Exposure** (cigarettes, cigars, pipe, dip, chew, snuff)
❑Never used ❑ Exposed to smoke
❑ Past user: type _____
❑Use now: type_____
(# per day _____)

**Alcohol or Street Drugs**
❑None
❑ Seldom: type_____
❑Occasional: type_____
❑Frequent : type_____

**Mental Health**: (*in past 90 days)*
❑No Problem
❑Mild/Moderate Depression
❑Severe Depression
❑ Thoughts of harming self / others

**Dental Health**
❑Brush daily ❑Floss daily
❑Visit dentist every 6 months

**Water Source:**
❑ Well ❑ Cistern
❑ Bottled ❑ City

**Travel:** ❑No travel outside USA
❑Traveled outside USA:
Country/Year_____/_____

**Abuse / Neglect / Violence:** ❑ No fear of harm ❑Pressure to have sex ❑Daily needs not met ❑Forced sexual contact ❑Exploitation ❑Fear of verbal/physical abuse ❑Sex for money or drugs

**Developmental Assessment:** Choose your (the patient's) age below and check tasks achieved.

| 1-3 months | 4-6 months | 7-9 months | 10-12 months | 13-18 months | 19-24 months |
|---|---|---|---|---|---|
| ❑Equal movements<br>❑Lifts head<br>❑Responds to sound<br>❑Regards face<br>❑Smiles | ❑Hands together / Reach<br>❑Squeals<br>❑Bears leg weight<br>❑Rolls over<br>❑Turns to sound | ❑Sits without support<br>❑Looks for object<br>❑Stands holding on<br>❑ "Mama" or "Dada"<br>❑Pulls to stand | ❑Combines syllables: "dadadada"<br>❑Thumb finger grasp<br>❑Claps hands<br>❑Stands – 5 seconds | ❑Stands alone or walks<br>❑Stoops / Recovers<br>❑Plays ball / Scribbles<br>❑Drinks from cup<br>❑Knows 3 words | ❑Uses spoon / fork<br>❑Runs / Kicks ball<br>❑Stacks 3 blocks<br>❑Knows 6 words<br>❑Removes garment |
| **2-3 years** | **4-5 years** | **6-7 years** | **8-10 years** | **11-15 years** | **16-21 years** |
| ❑Combines words<br>❑Names pictures / color<br>❑Jumps up<br>❑Puts on clothing<br>❑Wash / dry hands<br>❑Names friend | ❑Speaks clearly<br>❑Hops on one foot<br>❑Dresses, no help<br>❑Brushes teeth, no help<br>❑Copies +<br>❑Draws person | ❑Heel to toe steps<br>❑Knows alphabet<br>❑Counts<br>❑Knows right vs. wrong<br>❑Prints letter | ❑Same sex friends<br>❑Aware of outside world<br>❑Builds self-confidence<br>❑Seeks independence<br>❑Peer influence | ❑Seeks privacy<br>❑Takes some risks<br>❑Same sex friends<br>❑Different sex friends<br>❑Understands rules<br>❑Good self-image | ❑Self Confidence<br>❑Friends important<br>❑Less time with family<br>❑Thoughts of future<br>❑Questions rules<br>❑Sexual identity |

**Patient/ Caregiver Signature:** **Healthcare Provider Signature:** **Date:**

# TO BE COMPLETED BY HEALTHCARE PROVIDER

***Only for patients ages 0-5 years***

Mother's general health during pregnancy:
❑Good ❑ Fair ❑ Poor
At time of delivery, did mother have HIV: ❑ yes ❑ no
Hepatitis: ❑ yes ❑no
Explain any problems:

During pregnancy did mother:
Smoke ❑ yes ❑ no
SHS ❑ yes ❑ no
Drink alcohol ❑ yes ❑ no
Use street drugs ❑ yes ❑ no
TYPE:

Birth Information
Delivery: ❑ vaginal ❑ cesarean
If cesarean, explain why:
Weeks gestation:
Birth weight:

Home with mom from hospital: ❑ yes ❑ no
If no, explain why not:

Metabolic screening completed: ❑ yes ❑ no

Initial feeding at birth: ❑ bottle ❑ breast
Is this child breastfeeding now: ❑ yes ❑ no
# feedings in 24 hours:
Explain any problems:

Is this child bottle feeding: ❑ yes ❑ no
What formula:
Ounces in 24 hours:
Explain any problems:

Caretaker concerned about any of the following:
Emotional development ❑ yes ❑ no
Attention span ❑ yes ❑ no
Behavior ❑ yes ❑ no
Academics ❑ N/A ❑ yes ❑ no
Neglect ❑ yes ❑ no

Has this child had any of the following diseases:
Measles ❑ yes ❑ no
Mumps ❑ yes ❑ no
Rubella ❑ yes ❑ no
Chickenpox ❑ yes ❑ no
Meningitis ❑ yes ❑ no
Rotavirus ❑ yes ❑ no
Pneumonia ❑ yes ❑ no
Pertussis ❑ yes ❑ no
Hib ❑ yes ❑ no
Hepatitis ❑ yes ❑ no
RSV ❑ yes ❑ no

(Girls) Age menstruation onset: ❑ NA
LMP: _____/_____/_____
Does pt examine breasts monthly? ❑ yes ❑ no

If sexually active, # of partners: lifetime _____ Last 60 days _____ Last 30 days _____
Birth control used: ❑ yes ❑ no Type:

Other health concerns:

Frequent problems with any of the following:
Nasal infections ❑ yes ❑ no
Ear Infections ❑ yes ❑ no
Throat infections ❑ yes ❑ no
Asthma attacks ❑ yes ❑ no
Constipation ❑ yes ❑ no
Diarrhea ❑ yes ❑ no
Urinary tract infections ❑ yes ❑ no
Bedwetting ❑ yes ❑ no
Swallowing ❑ yes ❑ no
Vomiting ❑ yes ❑ no
Refusal to eat ❑ yes ❑ no
Headaches ❑ yes ❑ no
Vision ❑ yes ❑ no
Hearing ❑ yes ❑ no
Bleeding ❑ yes ❑ no
Other:

(Boys) Does patient examine testicles monthly?
❑ yes ❑ no

**Immunization Status:** ❑ Up to date by patient report ❑ Records Requested ❑ See Vaccine Administration Record
❑ Vaccines given today:

**Lead Assessment:** Verbal Risk Assessment: ❑N/A ❑ negative ❑ positive risk factor_____
Tested Today: ❑ yes ❑ no Referred for testing: ❑ yes ❑ no

**Preventive Health Education: topics discussed today**
❑ Child development
❑ Immunizations
❑ Dental
❑ Hearing/Vision
❑ Lead exposure(ACH-25a)
❑ Diet / Nutrition
❑ Physical activity
❑ Safety
❑ Mental Health
❑ DV/SA
❑ ATOD/Cessation/SHS
❑ Diabetes
❑ Preconception /Folic Acid
❑ Prenatal / Genetics
❑ CVD
❑ Arthritis
❑ Osteoporosis
❑ Cancer
❑ Pelvic / Pap
❑ SBE /Mammogram
❑ STE / PSA
❑ HRT
❑ STD / HIV
❑ Minor FP: Sexual coercion. Abstinence. Benefits of parental involvement in choices.
❑ Options counseling

**Educational Handouts:**
❑ Age-appropriate Points to Remember
❑FPEM ❑PTEM ❑CSEM
❑ Other:

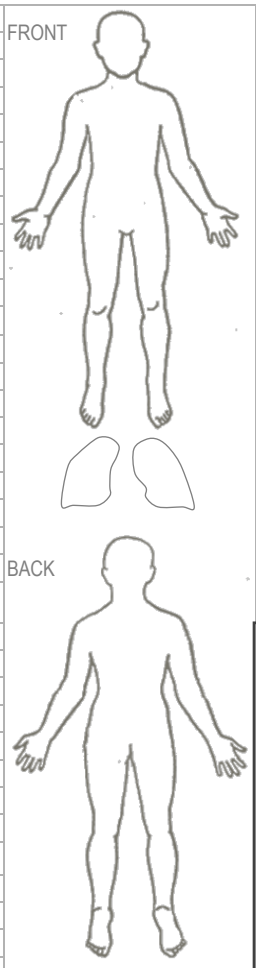
**Patient (or caretaker) verbalizes understanding of education given ❑**

**Healthcare Provider Signature:** **Date:**

***SUBJECTIVE / PRESENTING PROBLEM:***

***OBJECTIVE:*** **General Multi-System Examination**

| SYSTEM | | NL | ABNORMAL |
|---|---|---|---|
| Constitutional | General appearance | | |
| | Nutritional status | | |
| | Vital signs | | |
| HEENT | Head: Fontanels, Scalp | | |
| | Eyes: PERRL | | |
| | Conjunctivae, lids | | |
| | Ear: Canals, Drums | | |
| | Hearing | | |
| | Nose: Mucosa / Septum | | |
| | Mouth: Lips, Palate | | |
| | Teeth, Gums | | |
| | Throat: Tonsils | | |
| Neck | Overall appearance | | |
| | Thyroid | | |
| Respiratory | Respiratory effort | | |
| | Lungs | | |
| Cardiovascular | Heart | | |
| | Femoral / Pedal pulses | | |
| | Extremities | | |
| Chest | Thorax | | |
| | Nipples | | |
| | Breasts | | |
| Gastrointestinal | Abdomen | | |
| | Liver / Spleen | | |
| | Anus / Perineum | | |
| Genitourinary | Male: Scrotum | | |
| | Testes | | |
| | Penis | | |
| | Prostate | | |
| | Female:Genitalia | | |
| | Vagina | | |
| | Cervix | | |
| | Uterus | | |
| | Adnexa | | |




| SYSTEM | | NL | ABNORMAL |
|---|---|---|---|
| Lymphatic | Neck, Axilla, Groin | | |
| Musculoskeletal | Spine | | |
| | ROM | | |
| | Symmetry | | |
| Skin / SQ Tissue | Inspection(rashes) | | |
| | Palpation (nodules) | | |
| Neurological | Reflexes | | |
| | Sensation | | |
| Psychiatric | Orientation | | |
| | Mood / Affect | | |

**Tanner Stage:** ❑ typical ❑ atypical

**X-Ray***:* Type:
Date taken:
Date read:
Date compared with:
Result: ❑No Change ❑Neg/Non-remarkable ❑Improved ❑Worsening

**TB Classification:** ❑ TB suspect
❑0 No TB exposure, not infected
❑I TB exposure, no evidence of infection
❑II TB infection, without disease
❑III TB, clinically active
❑IV TB, not clinically active
Site of infection: ❑Pulmonary __Cavity __Non Cavity ❑ Other:

**EXPLANATION OF ABNORMAL FINDINGS:**

**ASSESSMENT:**

**PLAN:**

**Testing today***:* ❑ N/A
❑ GC ❑ Chlamydia
❑ UA ❑ TST
❑ VDRL ❑ HIV
❑ Pap ❑Lead
❑ Hgb ❑ Cholesterol
❑ Blood Glucose
❑ Urine PT / UCG: ❑Pos ❑Neg
Planned pregnancy? ❑ Yes ❑ No
❑Other:

**Medications:** ❑ N/A
❑ MV / Folic Acid
# of bottles given _____
❑ Fluoride varnish applied
❑ Fluoride drops
❑ Other:

**Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment:** ❑ N/A
❑ Vision / Hearing ❑ FBS / GTT
❑ Speech ❑ Lipid Screen
❑ Dental ❑ Pap Smear
❑ Hgb ❑ Mammogram
❑ Sickle Cell ❑ Ultrasound
❑ Lead ❑ TST / CXR
❑ UCG / HCG ❑ Liver Panel
❑ Developmental Scr. Tests
❑ Other:

**Referrals made:** ❑ N/A
❑ PMD ❑ HANDS
❑ Pediatrician ❑ WIC
❑ Specialist: ❑ Dental
❑ Radiology ❑ FP
❑ MNT with RD ❑ STD
❑ Medicaid
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Cooper Clayton Classes
❑ Other:

**Healthcare Provider Signature:** **Date:** **Recommended RTC: Well-child exam**_____
**Immunizations**_____
**Other:** _____