

MIU Pediatric Information

Patient Name: \_\_\_\_\_

Chart # / Office: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS:**

**What is your reason for today's visit?** \_\_\_\_\_

**GENERAL REVIEW OF SYSTEMS:** Please answer each question listed below with a check mark on the line.

**Is your child currently having any of the following?**

- |                      |                |                 |                |                  |                |
|----------------------|----------------|-----------------|----------------|------------------|----------------|
| Hearing Problems?    | Yes ___ No ___ | Fevers?         | Yes ___ No ___ | Constipation?    | Yes ___ No ___ |
| Painful Urination?   | Yes ___ No ___ | Back Ache?      | Yes ___ No ___ | Chest Pain?      | Yes ___ No ___ |
| Seasonal Allergies?  | Yes ___ No ___ | Skin Rashes?    | Yes ___ No ___ | Depression?      | Yes ___ No ___ |
| Bleeding Tendencies? | Yes ___ No ___ | Headache?       | Yes ___ No ___ | Growth Problems? | Yes ___ No ___ |
| Shortness of Breath? | Yes ___ No ___ | Blurred Vision? | Yes ___ No ___ |                  |                |

Please describe any problem above or any other problem not mentioned: \_\_\_\_\_

**MEDICATIONS:**

Is your **child CURRENTLY** taking any medications? If yes, please list: \_\_\_\_\_

Please list any **allergies** your child has to medications: \_\_\_\_\_

What was the reaction? \_\_\_\_\_

*Does your child require medications or antibiotics before procedures? Yes \_\_\_ No \_\_\_*

**PAST MEDICAL / FAMILY / SOCIAL HISTORY:** (Please Check all that apply and provide information below)

- |   |                 |                |                 |                      |                |
|---|-----------------|----------------|-----------------|----------------------|----------------|
| Does <b>YOUR CHILD</b> have a history of: | Premature Birth | Yes ___ No ___ | Eating Problems | Yes ___ No ___       |                |
| HIV Exposure                              | Yes ___ No ___  | Diabetes       | Yes ___ No ___  | High blood Pressure  | Yes ___ No ___ |
| Heart Disease                             | Yes ___ No ___  | Asthma         | Yes ___ No ___  | Heart Valve problems | Yes ___ No ___ |
| Kidney Disease                            | Yes ___ No ___  | Cancer         | Yes ___ No ___  | Spinal Cord Problems | Yes ___ No ___ |
| Lung Problems                             | Yes ___ No ___  | Hepatitis      | Yes ___ No ___  |                      |                |

Has <b>anyone in your FAMILY</b> had:	Cancer	Yes ___ No ___	Heart Problems	Yes ___ No ___
	Kidney Disease	Yes ___ No ___	Diabetes	Yes ___ No ___

**SOCIAL HISTORY:**

Does anyone in the home smoke? Yes \_\_\_ No \_\_\_ Did the birth mother receive prenatal care? Yes \_\_\_ No \_\_\_

Please list **YOUR CHILD'S** Medical Problem / Surgical History: (Give approximate dates for surgeries / hospitalization.)

**Major Medical Problems**

**Past Surgeries / Hospitalizations**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Form Completed By: \_\_\_\_\_

Relation \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

OFFICE USE ONLY

**ROS CHANGES:**

Constitutional _____	Cardiovascular _____	Respiratory _____
Skin _____	Hem/Lymph _____	Psych _____
Neuro _____	Eyes _____	GI _____
ENT _____	Musc/Skel _____	Endo _____
	Allergy/Imm _____	

**PFSH:** Meds: \_\_\_\_\_ Other: \_\_\_\_\_

**PERSONAL:** \_\_\_\_\_

**FAMILY:** \_\_\_\_\_

**SOCIAL:** \_\_\_\_\_

**UPDATED BY:** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**ROS CHANGES:**

Constitutional _____	Cardiovascular _____	Respiratory _____
Skin _____	Hem/Lymph _____	Psych _____
Neuro _____	Eyes _____	GI _____
ENT _____	Musc/Skel _____	Endo _____
	Allergy/Imm _____	

**PFSH:** Meds: \_\_\_\_\_ Other: \_\_\_\_\_

**PERSONAL:** \_\_\_\_\_

**FAMILY:** \_\_\_\_\_

**SOCIAL:** \_\_\_\_\_

**UPDATED BY:** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**ROS CHANGES:**

Constitutional _____	Cardiovascular _____	Respiratory _____
Skin _____	Hem/Lymph _____	Psych _____
Neuro _____	Eyes _____	GI _____
ENT _____	Musc/Skel _____	Endo _____
	Allergy/Imm _____	

**PFSH:** Meds: \_\_\_\_\_ Other: \_\_\_\_\_

**PERSONAL:** \_\_\_\_\_

**FAMILY:** \_\_\_\_\_

**SOCIAL:** \_\_\_\_\_

**UPDATED BY:** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_