Barton
Family Medicine – Pediatrics

Patient Name: _____ Date of Birth: _____

Date: _____

1. What is the reason for todays visit?

_____

_____

2. Please place a check mark next to any symptoms your child may have had over the last 2 weeks.

Constitutional		Eyes		Gastrointestinal		Endo/Heme/Allergy	
Fever		Blurred Vision		Heartburn		Easily bruise/bleed	
Chills		Double Vision		Nausea		Allergies	
Weight Loss		pain with light (photophobia)		Vomiting		Ex thirst (Polydipsia)	
Fatigue (Malaise)				Abdominal pain		**Neurological**	
Excess perspiration (Diaphoresis)		Eye pain		Diarrhea		Dizziness	
		Eye discharge		Constipation		Headaches	
Weakness		Eye redness		Blood in stool		Tingling	
Skin		**Cardiovascular**		Black stools (Melena)		Tremor	.
Rash		Chest pain				Sensory change	
Itching		Palpitations		**Genitourinary**		Speech change	
HENT		Shortness of breath when laying flat (Orthopnea)		Painful urination (dysuria)		Focal weakness	
Hearing loss						Seizures	
Ringing in ears (Tinnitus)				Urgency		Loss of consciousness (LOC)	
		Pain in legs-walking Due to poor circulation		Frequent urination			
Ear pain				Blood in urine (Hematuria)		**Psychiatric**	
Ear discharge		Leg Swelling				Depression	
Nosebleed		Sudden shortness of breath in sleep (PND)		Flank (side) pain		Suicidal ideas	
Congestion				**Musculoskeletal**		Substance abuse	
Sinus pain		**Respiratory**		Muscle pain (Myalgia's)		Hallucinations	
High pitched sound during breathing in neck or throat (Stri)		Cough				Nervous/Anxious	
		Coughing up blood (Hemoptysis)		Neck pain		Insomnia	
Sore throat				Back pain		Memory loss	
		Sputum production		Joint pain			
		Shortness of breath		Falls			
		Wheezing (Lungs)					

3. Please list any medications that you would like refilled and your preferred pharmacy:

_____

_____

4. Please list any referrals you may need:

_____

_____

Revised 03/29/18

Barton Family Medicine

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MEDICATION AND ALL OTHER ALLERGIES

Please list any allergies, adverse reactions, or side-effects to medications your child may have experienced:

CURRENT MEDICATIONS

Name	Strength	Dose	Reason

PAST MEDICAL HISTORY

Chicken Pox?	Yes	No	Strep throat? Approximate number of times:	Yes	No	Tonsillitis? Approximate number of times:	Yes	No	Asthma?	Yes	No
Measles?	Yes	No	Has your child ever had an EEG (Electroencephalogram)?	Yes	No	Ear Infections? Approximate number of times:	Yes	No	Blood Transfusions?	Yes	No
Mumps?	Yes	No	Psychological evaluations?	Yes	No	Heart Murmur?	Yes	No	Cancer?	Yes	No
Rubella?	Yes	No	Hearing tests?	Yes	No	HIV/AIDS?	Yes	No	Seizures?	Yes	No
Scarlet Fever?	Yes	No	Speech/language tests?	Yes	No	Meningitis?	Yes	No	Sickle Cell?	Yes	No
Pneumonia?	Yes	No	Diabetes Mellitus?	Yes	No	Parathyroid Disorder?	Yes	No	Clotting Disorder?	Yes	No
Frequent Colds?	Yes	No	Exposure to solvents or heavy metals?	Yes	No	Adrenal Disorder?	Yes	No	Diabetes?	Yes	No
Rheumatic Fever?	Yes	No	Exposure to pesticides/herbicides or other toxic chemicals?	Yes	No	Allergies?	Yes	No	Pituitary Disease?	Yes	No
Tonsillitis? Approximate number of times:	Yes	No	Low birth weight?	Yes	No	Anemia?	Yes	No	Failure to thrive?	Yes	No
Ear Infections? Approximate number of times:	Yes	No	High birth weight?	Yes	No	Irregular heart beat?	Yes	No	Urinary tract infections?	Yes	No

SURGICAL HISTORY

Please list the date and type of any surgeries your child may have had:

Patient Name: Birth Date:

FAMILY HISTORY

Please place a check mark under each disease that pertains to each family member.
Please add any additional diseases or relatives as needed to "Add:"

Relationship	Alive?		Age at death	Arthritis	Lung DZ	Genetic	Cancer	Psychiatry	Diabetes	Heart DZ	Hypertension	Hyperlipidemia	Stroke	Alcohol/Drug	Add:	Add:
Mother	Yes	No														
Father	Yes	No														
Sister	Yes	No														
Brother	Yes	No														
Maternal Aunt	Yes	No														
Maternal Uncle	Yes	No														
Paternal Aunt	Yes	No														
Paternal Uncle	Yes	No														
Maternal GM	Yes	No														
Maternal GF	Yes	No														
Paternal GM	Yes	No														
Paternal GF	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? Yes No

If yes please explain:

Mother's age at child's birth: _____

Mother's health during pregnancy:

Bleeding	**Nausea**	**Physical or emotional trauma**
Illness	**Hypertension**	**Cigarettes, alcohol, drug use**
Medications	**Diabetes**	**Thyroid problems**

SOCIAL HISTORY

Please list the number and relationship of persons living in the home: _____

Is your child exposed to second hand smoke? _____

Please list the number and type of pets: _____

Is there a history of sexual, mental/emotional, physical abuse? _____

If so, at what age and by whom?

Childs sleep patterns:

Age began sitting: Crawling Walking: Talking:

DIET

Please describe your child's typical daily diet:

Breakfast:_____ Lunch: _____ Snacks: _____

Dinner: _____ Drinks: _____

Food intolerances:

Breast Fed: Y/N If yes how long: _____ Formula: Y/N Type: _____

Age began solids: _____ Which foods: _____

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IMMUNIZATIONS

Please indicate if your child has received any of the following vaccines and the dates that they were administered.
Please provide a copy of your child's immunization record.

	First	Second	Third	Fourth	Fifth		
(Polio) OPV or IPV						NO	YES
Diptheria, tetanus, and pertussis DtaP/DTP/DT/Td						NO	YES
(Measles, mumps, rubella) MMR						NO	YES
(Haemophilus Influenzae B) HIB MENINGITIS						NO	YES
HEPATITUS B							
HEPATITUS A							
(Chickenpox) VARICELLA						NO	YES
(Tuberculosis) TB						NO	YES
(Human Papilloma Virus) HPV						NO	YES
Influenza FLU						NO	YES
(Pneumococcal) PCV						NO	YES
(Meningococcal) MCV						NO	YES
Rotavirus							

Has your child ever experienced an adverse reaction to any immunization? If so, please explain:

_____

BIRTH HISTORY

Birth Length: _____ Birth Weight: _____ Gestational Age: _____

Type of delivery: _____ Premature Full Term Late

Hospital where your child was born: _____ Duration of labor: _____

Did your child have any of the following problems shortly after birth? (circle all that apply)

Rashes	Birth injuries	Cerebral Palsy
Jaundice	Seizures	Birth defects
Colic	Fever	Breech
Other: _____	Blue baby	