

Patient Name _____ DOB _____ SSN _____
 Today's Date _____ Guarantor _____ Legal Guardian _____
 Weight _____ Height _____ Age _____
 Primary Physician _____ Referral Physician _____

Chief Complaint

Why are you seeing the doctor today?

Describe events around the reason for today's visit. _____

Location _____ How long has it been present? _____

Description of the pain: dull sharp tingling other _____

When does it occur? at rest with activity at night other _____

Any other symptoms associated with current problem? _____

Severity: One a scale of 1-10, how severe is the pain? (1 - very little and 10 - excruciating/can't function)

1 very little 2 3 4 5 6 7 8 9 10 excruciating/can't function

What makes it better or worse? pain medicine ice heat rest activity elevation

Context: How did it occur? _____ Is it better? _____ Is it worse? _____

Review of Symptom

Are you (or the child) currently having or have had problems with (check all that apply and explain):

Constitutional	No	Yes	Fatigue	Fever	Weight loss	Headache	Other _____
Eyes	No	Yes	Blurred Vision	Glasses	Other _____		
Ears/Nose/Throat	No	Yes	Congestion	Hearing loss	Jaw discomfort	Other _____	
Lungs, Breathing	No	Yes	Shortness of breath	Wheezing	Cough	Other _____	
Heart	No	Yes	Chest pain	Irregular heartbeat	Heart murmurs	Explain _____	
Gastrointestinal	No	Yes	Nausea	Vomiting	Stomach aches	Constipation	Diarrhea Other _____
Bladder	No	Yes	Incontinence	Urinary Tract Infections	Difficulty urinating	Other _____	
Endocrine	No	Yes	Diabetes	Thyroid problems	Delays in growth	Hypertension	Hypotension
Musculoskeletal	No	Yes	Joint pain	Leg pain	History of broken bones	Other _____	
Bleeding problems	No	Yes	Anemia	Prolonged bleeding after cut/injury	Other _____		
Neurological	No	Yes	Numbness/tingling	Dizziness	Headaches	Frequent falls	Other _____
Integumentary	No	Yes	Rashes	Skin disorders	Connective tissue disorders	Other _____	Psychiatric No
	Yes		Changes in mood or behavior		Change in sleep patterns	Other _____	Immunologic/Allergic
	No	Yes	Asthma	Communicable diseases	Chronic rashes	Hay fever	Other _____

Current medications and dosages

Are you allergic to any medicine? No Yes

If yes, please list and type of reaction: _____

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