West Side Pediatrics, Inc.

Patient's Name: _____Date of birth: _____ Today's date: _____

Who is **here with the patient today?** _____
Do you have any concerns today? Please circle one.

NO, my child is doing well **YES,** I have concerns today My concerns are: _____

*(Please note, if extra time is needed during your well check for management of **chronic conditions or acute illnesses**, or if a **pre-op evaluation** is also needed today, there are additional codes required on the insurance claim that **may** generate a co-pay, depending on your contract with your insurance company.)*

Do **you or your child** have any **communication needs**? (Please circle)
NONE Hearing Impaired Vision Impaired Need Language Interpreter

Has your child been taking any **prescription medications, over-the-counter medications, vitamins, or supplements?**
Please include all **oral medications, inhalers, skin creams, eye or ear drops, shots, etc.**
NO YES Please list:
If meds are by prescription, does your child **take these medications as prescribed?**
YES NO N/A If no, please explain:_____
Are you **comfortable using these medications**?
YES NO N/A If no, please explain:_____
Do you have **medication questions**?
NO YES N/A If yes, please explain:_____

Do you have the number for **poison control** (1-800-222-1222) at home or in your cell phone?
YES NO I just wrote put it in my phone

Are there **smoke detectors** in the home?
YES NO

Are there **carbon monoxide detectors** in the home?
YES NO All electric home

If there are **guns** in the home, are they stored in a **secure / locked location**?
Not applicable (don't own any) Yes, they are locked up No, they are not locked up Prefer not to answer

Where does the patient **sit in the car**? (Circle all that **ever** apply.)
Rear-facing car seat Front-facing car seat Booster seat
Back seat with seat belt Front seat with seat belt No seat belt (either sometimes or always)

Healthy Tip**: babies should be **rear-facing until 2 years old**; after that, kids should be in a regular forward-facing car seat until they reach the height / weight limits for that seat, then transition to a booster seat; they should be in a **booster seat until 4 foot 9 inches tall**; kids should be in the **back seat until 13 years old.

Does the patient wear a **helmet when riding a bike or scooter**?
All of the time Most of the time Sometimes Never Doesn't ride

Has there been **any significant stress or stressful event** in the child's life since the last check-up?
(For example, new school, living situation, illness or death in the family, change in relationship status of caregivers, etc.)
NO YES Please list:

Does anyone in the household **smoke** (including patient)?
NO YES, inside YES, outside

Patient's Name: _____

How many ounces of the following does the patient drink each day? (Note: 1 cup=8 ounces)

Water_____oz Whole milk_____oz Low-fat or fat-free milk_____oz

100% juice_____oz Pop / soda / fruit punch_____oz Sports drinks_____oz

How many servings of **fruits and vegetables** does the patient eat each day? _____

How many **hours per day** does your child spend **watching TV, using the computer, or playing video games**? _____

Does your child have or use a tablet / iPad, smartphone, TV or computer in their room?

NO YES

Healthy Tip: Give devices a curfew! We recommend that screens be turned off 30-60 minutes before bed and that screen time for entertainment be limited to 1-2 hours per day.

Do you have any concerns about your child's **sleep**, including sleep patterns, snoring, or apnea (pausing or gasping)?

NO YES If yes, please describe: _____

If the patient is outside in the sun for longer than 30 minutes, does he / she **wear sunscreen**?

All / Most of the time Sometimes Never

Has your child had any **surgery or procedure** at any time in the past?

NO YES Please list:

Does your child have any **food or drug allergies**?

NO YES Please list:

Please list **each current physical or behavioral diagnosis** that the patient has been given by a physician or other professional. (For example, asthma, allergies, ADHD, chronic ear infections, depression, etc.)

1.
2.
3.

Does your child see a **specialist**? (For example, an allergist, cardiologist, dermatologist, gynecologist, psychologist, etc.)

NO YES Please list:

Do you have **any questions about your child's health conditions or need more information?**

NO YES

Has your child had any recent **illness, injury, or trip to the emergency room / urgent care?**

NO YES Please list:

Please list **any physical or mental illnesses in the immediate family** (for example, high cholesterol, heart attack or stroke, sudden or unexplained death, diabetes, cancer, depression, anxiety, bipolar disorder, ADHD, thyroid problems, inherited diseases, substance abuse, asthma, etc.) **If there is NO illness, check here____**

Patient's MOM **Patient's DAD** **SISTERS** **BROTHERS**

Has anyone in the extended family (grandparents, etc) had a **heart attack or sudden heart death before age 55?**

NO YES If yes, please list the relationship, age, and condition _____

Has anyone in the extended family had **high cholesterol or needed cholesterol medication before age 55?**

NO YES If yes, please list the family member(s)_____

Who **lives at home** with the patient? Please list: _____