PATIENT SELF-ASSESSMENT

Person completing form:________________________________ Relationship to Patient:____

Daytime contact # ____

Current primary care physician:____ Phone # ____

Have there been any recent changes in family or living situation (divorce/separation, deaths, financial problems, substance abuse, etc.)? ____

Since the last visit has your child had any (if yes, describe below)

Major illnesses: □ yes □ no Hospitalizations: □ yes □ no Surgeries: □ yes □ no Allergies: □ yes □ no

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Diet: Type of formula or milk:___________________________________ or bolus (amount/how often)__________________________________

*If on tube feeds: drip (rate + # hrs/day) _______________________

Current home care company:____ Phone #:____________________________

Review of Systems: Please place a checkmark in the appropriate box if your child has had any problems, since your last visit, with:

General
- □ Recurrent fevers/temperatures
- □ Weight loss
- □ Weight gain

Gastrointestinal (Stomach/Intestines)
- □ Constipation
- □ Soiling underpants
- □ Diarrhea
- □ Vomiting/spitting up
- □ Heartburn
- □ Blood in stool
- □ Difficulty swallowing
- □ Stomach pain
- □ Nausea
- □ Reflux
- □ Liver problem/jaundice/hepatitis

Heart/Blood vessels
- □ Heart murmur
- □ Heart problems
- □ Chest pain
- □ Paliptations
- □ Irregular heart beat
- □ Blood pressure problems

Breathing/Lungs/Chest
- □ Coughing
- □ Wheezing
- □ Asthma
- □ Shortness of breath
- □ Apnea (stops breathing)
- □ Pneumonia
- □ Aspiration
- □ Tracheostomy

Endocrine (Glands)
- □ Thyroid problems
- □ Poor growth
- □ Other hormone/gland problems

Hematologic (Blood problems)
- □ Bleeding disorder/easy bleeding
- □ Anemia
- □ Received blood
- □ Easy bruising
- □ Swollen lymph nodes
- □ Lumps/growths

Genital/Urinary System
- □ Pain/burning with urination
- □ Blood in urine
- □ Increased frequency/amount of urine
- □ Swelling/retaining water
- □ Urinary tract/kidney problems
- □ Menstrual problems
- □ Age at first menstrual period _______
- □ Date last menstrual period ended ______________

Musculoskeletal
- □ Joint problems
- □ Weakness
- □ Scoliosis (curved spine)

Skin
- □ Skin rashes
- □ Acne
- □ Easy bruising
- □ Birthmark

Neurologic (Brain/Nerves)
- □ Developmental delay
- □ Headaches
- □ Seizures
- □ Dizziness
- □ Fainting
- □ ADHD (hyperactivity)
- □ Decreased sensation
- □ Decreased muscle strength
- □ Other neurologic problems
- □ Migraines

Psychology
- □ Depression
- □ Anxiety
- □ Memory loss
- □ Sleeping difficulties
- □ Hallucinations
- □ Paranoia
- □ Phobia
- □ Confusion

Eyes
- □ Wear glasses
- □ Blurry vision
- □ Double vision
- □ Eye pain
- □ Blind

Ears/Nose/Throat
- □ Ear pain
- □ Ear infections
- □ Discharge from ears
- □ Nose bleeds
- □ Sinus problems
- □ Mouth ulcers
- □ Trouble swallowing
- □ Hoarseness
- □ Sour taste in mouth
- □ Sore throat
- □ Dental problems

Allergy/Immune System
- □ Allergies
- □ Immune problems
- □ Frequent infections
- □ Unusual infections