

# STONY BROOK SURGICAL ASSOCIATES

## PEDIATRIC PATIENT ASSESSMENT FORM (new patients only)

Please complete all sections

<b>Patient Information</b>		HGT	WGT	SS#
Name (Last, First, MI)		MRN	DOB	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Status <input type="checkbox"/> Child <input type="checkbox"/> Single <input type="checkbox"/> Legally Married			
Name of Parent or Legal Guardian			Relationship	
Home Phone	Work Phone	Cell Phone		
Name of Pharmacy		Phone		
<b>Reason for Visit:</b> _____				
Do you have any pain related to your presenting complaint/condition? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes, Pain Tool must be completed)</i>				
<b>Birth History</b>		WGT	PREMATURE? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ wks	
<b>Complications (describe):</b> _____				
<b>Hospitalization/Surgery/Major Illness</b> <input type="checkbox"/> N/A				
<b>PROBLEM</b>	<b>YEAR</b>	<b>WHERE TREATED</b>	<b>DAYS IN HOSPITAL</b>	
Blood Transfusion <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Complications: _____				
<b>Medications</b> (Please list all medications you are currently taking, including vitamins and supplements)				
1. _____	4. _____			
2. _____	5. _____			
3. _____	6. _____			
Herbal medications? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Allergies to Medication? <input type="checkbox"/> No <input type="checkbox"/> Yes (type of reaction) _____				
Food Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify) _____				
<b>Gynecologic/Obstetric History (ENT patients do not need to complete)</b> <input type="checkbox"/> N/A				
Any Pregnancies? <input type="checkbox"/> No <input type="checkbox"/> Yes (how many) _____		How many children have you given birth to? _____		
How many abortions/miscarriages? _____		Date of last period _____		
Lumps on breasts? <input type="checkbox"/> No <input type="checkbox"/> Yes		Monthly breast exams? <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Social Exposures</b> <input type="checkbox"/> N/A				
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes		Cocaine <input type="checkbox"/> No <input type="checkbox"/> Yes	Narcotics/Drug Use <input type="checkbox"/> No <input type="checkbox"/> Yes	
Smokes Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, # of Yrs _____	# of Packs/Day _____	When Stopped _____	
Any recent exposure to contagious disease? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____				
Is your child or others exposed to second hand smoke inside or outside of home? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is your child or you currently in a domestic violence situation? <input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Personal/Social History</b>				
Residence <input type="checkbox"/> Live with Parents <input type="checkbox"/> Live Alone <input type="checkbox"/> Shelter <input type="checkbox"/> Other _____				
Who will assist in the patient's care <input type="checkbox"/> Parent <input type="checkbox"/> Family <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Self <input type="checkbox"/> Foster Agency <input type="checkbox"/> Other (specify name and phone) _____				
Can you read and understand English? <input type="checkbox"/> No <input type="checkbox"/> Yes		What is your first language? _____		
Religion _____		Race/Ethnicity _____		
Interpreter Necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient's Occupation <input type="checkbox"/> Student <input type="checkbox"/> Other _____		
Cultural & Religious Beliefs that May Affect Care <input type="checkbox"/> No <input type="checkbox"/> Yes _____				
Do you have any barriers to learning? <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Cognitive				

NAME \_\_\_\_\_

MRN# \_\_\_\_\_

**Personal/Family History** (Check all that apply for patient and/or family member)

IF YES	PATIENT/HOW OFTEN	FAMILY MEMBER/HOW OFTEN
Abdominal Pain	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Anesthesia Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Bleeding/Bruising Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Bowel Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Congenital Heart Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Constipation	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Cough/Wheezing	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Diabetes Mellitus	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Ear Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Eye Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Genetic Disorder	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Headaches	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Heart Trouble	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hepatitis	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hernia – Inguinal/Umbilical	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Joint/Limb Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Kidney Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Lung Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Mental Retardation/Illness	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hyperthermia/high temperature	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Moles that are changing?	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Nasal Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Neurological Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Rashes, Sores, Itching	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Seizure Disorder	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Skin Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Sleep Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Tonsil Infections	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Thyroid Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Stomach Pain	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Urination Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Weakness/Numbness	<input type="checkbox"/> _____	<input type="checkbox"/> _____
OTHER _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> CHECK IF NONE APPLY		

**Nutritional Data**

Is your child/the patient following a special diet?  No  Yes \_\_\_\_\_

Is your child/the patient:  Breast Feeding  On infant formula (specify) \_\_\_\_\_  On Solids

Unintentional Weight  Over/Under 5 lbs in 1 month  Over/Under 10 lbs in 3-6 months

Appetite  Good (eat 3+ meals/day)  Fair (1-2 meals/day)  Poor (less than 1 meal/day)

COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ ID # \_\_\_\_\_ DATE: \_\_\_\_\_