SICK VISIT INTAKE FORM

Pecan Tree Pediatrics

Date: _____

Name: _____

Reason for Visit: _____

Has your child had any **major illnesses** since your last office visit? ☐ No ☐ Yes _____
Has your child had any **surgeries** since your last office visit? ☐ No ☐ Yes _____
Has your child had any **hospitalizations** since your last office visit? ☐ No ☐ Yes _____

Please describe any other changes to your family history or social history here: ☐ None

_____
_____
_____

Briefly, describe your child's current symptoms:

_____
_____
_____

REVIEW OF SYSTEMS:
If your child is experiencing or has recently experienced any of the following, please mark below:

General
☐Fever: _____°F
☐Weight Loss
☐Weight Gain
☐Fatigue

Skin
☐Rash
☐Swelling
☐Dryness
☐Itching
☐Eczema
☐Color change
☐Infection
☐Change in hair
☐nails

Blood
☐Abnormal blood test
☐Bleed easily
☐Bruise easily
☐Anemia

Head
☐Headache
☐Head Injury

Neck
☐Swollen nodes
☐Stiffness
☐Pain

Eyes
☐Poor vision
☐Blurry vision
☐Sensitive to light
☐Pain
☐Redness
☐Discharge
☐Excess tearing
☐Double vision
☐Infections

Ears
☐Ear Pain
☐Poor hearing
☐Ringing in ears
☐Dizziness
☐Infection
☐Discharge
☐Excess ear wax

Nose/Sinuses
☐Runny Nose
☐Nasal stuffiness
☐Allergies
☐Nosebleeds
☐Sinus trouble

Mouth/Throat
☐Cavities
☐Cold sores
☐Canker sores
☐Hoarseness
☐Sore throat
☐Blisters

Lungs
☐Cough
☐Wheezing
☐Shortness of breath
☐Difficulty breathing

Heart
☐Heart murmur
☐Palpitations

Musculoskeletal
☐Joint pains
☐Stiffness
☐Backache
☐Muscle pain or cramps

Urinary
☐Pain
☐Blood in urine
☐Urgency
☐Incontinence
☐Bed wetting
☐Infections
☐Frequency
☐Urinating less

Endocrine
☐Heat intolerance
☐Cold intolerance
☐Excessive sweating
☐Excessive thirst
☐Excessive hunger
☐Excessive urination

Circulation
☐Leg cramps
☐Cold extremities

Digestion
Excess ☐ Belching
☐ Bloating
☐Passing Gas
☐Trouble swallowing
☐Heartburn
☐Nausea
Appetite ☐ Increased
☐Decreased
☐Vomiting
☐with blood
☐Abdominal pain
☐Constipation
☐Diarrhea
☐Blood in stool
☐Change in bowel habits
Stools ☐pale ☐black

Nervous System
☐Fainting
☐Blackouts
☐Seizures
☐Paralysis
☐Local weakness
☐Numbness
☐Tingling
☐Tremors
☐Memory

Mind
☐Nervousness
☐Lack of concentration
☐Memory issues

Emotions
☐Mood swings
☐Depression
☐Excess anger / sadness / frustration / mania / difficulty feeling or expressing emotions

PLEASE LIST OTHER:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____