

# Patient Update Information

David J. Siegler, M.D.

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Patient Sticker

Today's Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Male / Female Nickname \_\_\_\_\_

Date of Visit: \_\_\_\_\_ Previous Visit: \_\_\_\_\_

Reason for Visit \_\_\_\_\_  new problem  Old problem

Pediatrician or Family Physician \_\_\_\_\_  Same  Different

Person filling out form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

## Patient's Medical History since last visit:

<u>Has child had any:</u>	No	Yes	Details
Hospitalizations:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serious Illnesses:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injuries:	<input type="checkbox"/>	<input type="checkbox"/>	mo/yr _____ Passed out? _____ Confused? _____ Seen by Dr? _____
Medication Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Med: _____ Reaction: _____
Food/other allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Item: _____ Reaction: _____

## Present Medications None

Name	Dose	Reason for Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Past Medications stopped since last visit:

Name	Highest Dose	Reason Used	Reason Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**Family History:** Any new developments?  No  Yes: if yes, please provide details:

(circle only the disorders in the family & write person's relation to patient; ie. Mom, maternal uncle)

Migraines _____	Seizures _____	Clotting _____
Headaches _____	Epilepsy _____	Aneurysms _____
Tics _____	Passing out _____	Heart Disease _____
Cerebral Palsy _____	Muscles _____	Stroke under 50 _____

**Social History:** Patient lives with? \_\_\_\_\_

Parents are:  Married  Divorced  Never Married  Separated

Custody (if applies): Mom has \_\_\_\_\_ % Dad has \_\_\_\_\_ % Documents available:  yes  no

Patient is a  Natural Child  Adopted  Foster Child (in DHS custody)  Other: \_\_\_\_\_

**School:** (circle): too young pre-school grade level \_\_\_\_\_

School \_\_\_\_\_ home-schooled home-bound other: \_\_\_\_\_

School Performance: A B C D F \_\_\_\_\_

**Any high risk behaviors?** (ie. alcohol/drug use, sexual activity)  no  yes \_\_\_\_\_

**Any social stressors or concerns?** \_\_\_\_\_

Any Developmental Changes or Concerns?  no  yes \_\_\_\_\_

**Any recent tests?**  no  yes \_\_\_\_\_

EEG (where?) \_\_\_\_\_

Head CT/ MRI (where?) \_\_\_\_\_

Labs (where?) \_\_\_\_\_

**Description of problem(s):**  Already filled out form  Did not fill out form: see below:

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Is patient's problem related to an injury or accident?  No  Yes: \_\_\_\_\_

If yes, do you plan a lawsuit or is a lawyer involved?  No  Yes: Attorney: \_\_\_\_\_

Attorney Tel# \_\_\_\_\_

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## Circle any of the following the patient is presently experiencing:

### General:

Fatigue                      Sleeps a lot                      Sleeps poorly

Recent Fevers    Weight Loss                      Weight Gain

### Ears-Nose-Mouth-Throat

Hearing problems: loss    ringing

Hoarse Voice                      Onset? \_\_\_\_\_

Chokes on food/drink    Onset? \_\_\_\_\_

### Respiratory

Shortness of breath    Onset? \_\_\_\_\_

Wheezing                      Onset? \_\_\_\_\_

Chronic Cough                      Onset? \_\_\_\_\_

### Genito-Urinary

Dark colored urine (like cola)

Wets self (toilet trained) at night    during day

Soils self (toilet trained) at night    during day

Menstrual periods                      Onset? \_\_\_\_\_

### Skin

Recurrent Rash of face / joints

Coffee spots                      How many? \_\_\_\_\_

White spots                      How many? \_\_\_\_\_

### Hematologic

Bruises easily

Bleeding takes long to stop

### Psych-Behav

Homocidal or Suicidal thoughts or attempts

Hallucinations                      Depressed

Perfectionistic                      Overly clean

Obsessive-Compulsive                      Lots of fears

Has many rituals

Anger problems                      Hurts others

Poor attention                      Is easily distracted

Hyperactive                      Acts without thinking

Is not very social                      Has no friends

Has poor eye contact                      Has been arrested

Dislikes seams / tags / tight clothes

### Eyes

Vision: poor    blind    wears contacts / glasses

Eye pain                      Onset? \_\_\_\_\_

Visual blackouts                      Onset? \_\_\_\_\_

Double vision                      Onset? \_\_\_\_\_

### Cardiovascular

Chest pains                      Onset? \_\_\_\_\_

Palpitations                      Onset? \_\_\_\_\_

Irregular heart beat                      Onset? \_\_\_\_\_

### Gastrointestinal

gags often                      Onset? \_\_\_\_\_

often nauseated                      Onset? \_\_\_\_\_

spits-up/vomits often                      Onset? \_\_\_\_\_

frequent diarrhea                      Onset? \_\_\_\_\_

chronic Constipation                      Onset? \_\_\_\_\_

### Musculo-Skeletal

muscle pains    muscle cramps

joint pain / swelling                      Onset? \_\_\_\_\_

reported curved spine

### Endocrine

Excessive thirst                      Frequent urination

Heat intolerance                      Cold intolerance

### Neuro (other than for reason for being here)

Headaches

Seizures

Staring spells

Tics

Involuntary movements

Learning Disability

Mental Retardation