Update Patient Information

David J. Siegler, M.D.

Date of Visit: ____________________________ __________________________ ☐ Same ☐ Different

Pediatrician or Family Physician

Reason for Visit ____________________________

Patient's Medical History since last visit:

Has child had any:	**No**	**Yes**	**Details**
Hospitalizations:	☐	☐	____
Surgeries:	☐	☐	____
Serious Illnesses:	☐	☐	____
Head Injuries:	☐	☐	mo/yr _______ Passed out? ______ Vomited? _______Seen by physician?___
Medication Allergies:	☐	☐	Med: __________________Reaction: ________________________
Food/other allergies:	☐	☐	Item: __________________Reaction: ______________________

Present Medications ☐None

Name	Dose	Reason for Use
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________

Past Medications:

Name	Highest Dose	Reason Used	Reason Stopped
____________	________	____________	________________
____________	________	____________	________________
____________	________	____________	________________
____________	________	____________	________________
____________	________	____________	________________

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

____

Home Life: Any new developments? ☐ No ☐ Yes: if yes, please provide details:

____

Name of school: __________________________ **Grade (s)he is in?** ______________________

Grades (s)he makes: ______________________ **Interests** ______________________________

Parents are ☐ **married**

☐ **divorced: Mom has** ______ % **Dad has** _____ %

☐ **other** ____

Patient is your: ☐ **Natural Child** ☐ **Adopted Child** ☐ **Foster Child** ☐ **Other:**__________

Who does (s)he lives with? ____

What is home life like? ____

What does mom and dad do? ____

Developmental History

Parental Developmental Concerns:

Milestone	Acquired No Yes	Age when acquired
Rolls over	☐ ☐	___________
Sits alone	☐ ☐	___________
Uses thumb-finger grasp	☐ ☐	___________
Uses “dada” “mama” correctly	☐ ☐	___________
Waves Bye-Bye	☐ ☐	___________
Walks well	☐ ☐	___________
Knows 3 – 5 words	☐ ☐	___________
Runs	☐ ☐	___________
Uses utensils	☐ ☐	___________
Combines words	☐ ☐	___________
Knows 5 – 6 body parts	☐ ☐	___________
Speech all understandable	☐ ☐	___________

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Patient Sticker

Today's Date: __________

Has the patient ever experienced problems with the following? Check Yes or No
Please provide details where appropriate:

	No	Yes			
General	☐	☐	Fatigue		Onset? ____________________
	☐	☐	Recurrent Fevers		Details: ____________________
	☐	☐	Weight Loss		Details: ____________________
	☐	☐	Weight Gain		Details: ____________________
Eyes	☐	☐	Poor Vision		Details: ____________________
	☐	☐	Eye Pain		Details: ____________________
	☐	☐	Visual Blackouts		Details: ____________________
	☐	☐	Double Vision		Details: ____________________
Ears-	☐	☐	Hoarse Voice		Details?____________________
Nose	☐	☐	Trouble Swallowing		Onset? ____________________
Mouth	☐	☐	Chokes on food/liquid often		Onset? ____________________
& Throat	☐	☐	Bloody nose difficult to stop		Onset? ____________________
CV	☐	☐	Episodes of pounding chest		Details: ____________________
	☐	☐	Episodic Chest Pain		Details: ____________________
	☐	☐	Skipped Heart Beats		Details: ____________________
Respiratory	☐	☐	Episodes of Shortness of breath		Details: ____________________
	☐	☐	Wheezing		Details: ____________________
	☐	☐	Chronic Cough		Details: ____________________
GI	☐	☐	Frequent Gagging		Details: ____________________
	☐	☐	Frequent Nausea		Details: ____________________
	☐	☐	Frequent Vomiting		Details: ____________________
	☐	☐	Gastro-esophogeal reflux		Details: ____________________
	☐	☐	Recurrent Diarrhea		Details: ____________________
	☐	☐	Chronic Constipation		Details: ____________________
Joint-Bones	☐	☐	Recurrent Joint Pain		Details: ____________________
	☐	☐	Recurrent joint Swelling		Details: ____________________
	☐	☐	Curved spine	Severity?	Onset? ____________________
Skin-Hair	☐	☐	Recurrent Facial Rash		Details: ____________________
	☐	☐	Recurrent Rash over Joints		Details: ____________________
	☐	☐	Coffee spots	How many? _______	Where? ____________________
	☐	☐	White spots	How many? _______	Where? ____________________
	☐	☐	Squishy bumps	How many? _______	Where? ____________________
	☐	☐	Hair thinning	(mild / severe)	Onset? ____________________

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	No	Yes		
Muscles	☐	☐	Long standing Muscle Pain	Details: ____________________
	☐	☐	Frequent Muscle Cramps	Details: ____________________
Endocrine	☐	☐	Excessively thirsty	Onset? ____________________
	☐	☐	Urinates very frequently	Onset? ____________________
Hematologic	☐	☐	Bruises easily	Details: ____________________
	☐	☐	Bleeding takes long to stop	Onset? ____________________

Has the patient ever experienced problems with the following? Check Yes or No

If yes then: **Circle** or **Check** appropriate answer **Please provide details where appropriate:**

	No	Yes		No	Yes	
Psych-Behav	☐	☐	Suicidal thoughts / attempts	☐	☐	Takes forever to do homework
	☐	☐	Homocidal thoughts	☐	☐	Trouble following directions
	☐	☐	Hears voices that aren't real	☐	☐	Perfectionistic
	☐	☐	Sees things that aren't real	☐	☐	Writes-erases-rewrites often
	☐	☐	Recent loss of someone close	☐	☐	Is very orderly/rigid to a fault
	☐	☐	Change in friends for the worse	☐	☐	Touches stuff all the time
	☐	☐	Reports being "depressed"	☐	☐	Makes noise constantly
	☐	☐	Seems sad a lot	☐	☐	Counts objects often
	☐	☐	Sleeps excessively	☐	☐	Repeats words often
	☐	☐	Gets angry beyond expected	☐	☐	Has rituals
	☐	☐	Is hyperactive	☐	☐	Obsessed with things
	☐	☐	Acts without thinking	☐	☐	Overly clean
	☐	☐	Is easily distracted	☐	☐	Overly fearful
	☐	☐	Often misplaces schoolwork	☐	☐	Dislikes seams / tags / tight clothes
	☐	☐	Fails to hand in schoolwork	☐	☐	Is not very social
	☐	☐	Disorganized to a fault	☐	☐	Won't make good eye contact

Additional Details:

Mark those neurologic issues below that are **in addition to the reason she/he came today**

	No	Yes		Details:
Neurologic	☐	☐	Headaches	____________________
	☐	☐	Attention problems	____________________
	☐	☐	Seizures with fever	____________________
	☐	☐	Seizures without fever	____________________
	☐	☐	Sleep problems	____________________
	☐	☐	Tics	____________________
	☐	☐	Involuntary movements	____________________
	☐	☐	Learning Disability	____________________
	☐	☐	Mental Retardation	____________________