

Portland Family Practice- **children age 0-4**
PRE-VISIT SUMMARY

Dear parent, thank you for completing this form. Please bring it with you to your child's appointment.

Patient's name: _____

DOB: _____

Visit date: _____

Reason for visit: _____

Accompanied by: _____

Past immunization reactions? _____ up to date on immunizations? _____

In day care? _____ with ? _____ At home? _____

Diet: Breast _____ Bottle _____ Both _____ ounces per day? _____

Any solid foods? _____ if so, balanced diet? _____

Daily supplemental vitamin/ fluoride? _____

Problems with bladder or bowels? _____ frequency of stools? _____

Sleeping habits: Sleeps in Bed _____ Crib _____ Co-sleep w/parents _____

How much TV or computer time daily? _____

Social interactions: Play group _____ Siblings _____ Early education _____

Would you like information about car seat safety checks? _____

Do you have questions about baby proofing your home? _____

Are there guns in the home? _____

Exposed to second hand smoke? _____

Current Medication(s), including vitamins, supplements/herbs –dose and quantity:

Medical History: Has your child had any of these problems: Diabetes - Cancer – Asthma –
Bowel or Urinary problems -Psychiatric Disorder/Depression/Anxiety – Bleeding Disorder –
Thyroid Disease - Kidney Disease – skin problems – motor or speech problems
ADD/ADHD - Other:

Allergies to Medications: _____ **Other:** _____

Surgical History and dates: _____

Hospitalizations and dates: _____

FAMILY HISTORY: Father Mother Siblings Extended Family

DATE OF BIRTH				
Alive or Deceased				
High Cholesterol				
Heart Disease				
Hypertension				
Diabetes				
Cancer				
Stroke				
Thyroid Disease				
Kidney disease				
Bleeding disorder				
Substance Abuse				
Depression				
Psychiatric Disorder				
OTHER Diseases not listed:				

Fathers (step-Father) name: _____ or legal guardian: _____

Mothers (step-Mother) name: _____ or legal guardian: _____

Siblings name(s) and ages:

Besides parents and siblings listed, who lives in your home? Grandparents, relatives or friends?

Social/Habit History:

Travel outside US? NO _____ Yes = where? _____

Do you use a smoke detector in your home? Yes _____ No _____

Do you have pets? _____

Name/location of the pharmacy you use the most? _____

CLINIC USE ONLY

Vitals: WT _____ HT _____ HC _____ BP _____ 2nd BP _____

Pulse _____ T _____ R _____ HR _____ O2 sat _____

Vision _____ corrected _____

BP supine _____ sitting _____ standing _____

HR supine _____ sitting _____ standing _____

