

Portland Family Practice- **children age 5-11**  
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 \_\_\_\_\_

Diet from the four food groups to include- Milk/Dairy products? \_\_\_\_\_ Meat ? \_\_\_\_\_

Grains, cereal, rice? \_\_\_\_\_ Vegetables/Fruits? \_\_\_\_\_

Do you take a supplemental vitamin/fluoride daily? \_\_\_\_\_

Up to date on Vaccinations? \_\_\_\_\_

Do you wear Seat Belts in the car? \_\_\_\_\_

Do you have regular dental check-ups every 6 months? \_\_\_\_\_

Grade in school? \_\_\_\_\_ average school grades are? \_\_\_\_\_

Have you had to repeat a grade? \_\_\_\_\_

Where do you go after school? \_\_\_\_\_

Do you play any sports/activities? \_\_\_\_\_

How many hours of exercise do you get daily? \_\_\_\_\_

Do you have friends? \_\_\_\_\_ Do you get along with your siblings? \_\_\_\_\_

How many hours daily is spent watching TV, or on the computer? \_\_\_\_\_

What are your favorite things to do? \_\_\_\_\_

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 ó Asthma ó  
Bowel or Urinary problems -Psychiatric Disorder/Depression/Anxiety ó Bleeding Disorder ó  
Thyroid Disease - Kidney Disease ó skin problems ó motor or speech problems  
ADD/ADHD - Other:

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medications:** \_\_\_\_\_ **Ot her:** \_\_\_\_\_

**Surgical History and dates:** \_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations and dates:** \_\_\_\_\_  
\_\_\_\_\_

-OVER-

**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 does anyone else live in the home? Grand parents, relative or other 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? \_\_\_\_\_

Do you feel safe? \_\_\_\_\_

**Name/location of the pharmacy you use the most?** \_\_\_\_\_

**CLINIC USE ONLY**

**Vitals:** WT \_\_\_\_\_ HT \_\_\_\_\_ HC \_\_\_\_\_ BP \_\_\_\_\_ 2<sup>nd</sup> BP \_\_\_\_\_

Pulse \_\_\_\_\_ T \_\_\_\_\_ R \_\_\_\_\_ HR \_\_\_\_\_ O2 sat \_\_\_\_\_

Vision \_\_\_\_\_ corrected \_\_\_\_\_

BP supine \_\_\_\_\_ sitting \_\_\_\_\_ standing \_\_\_\_\_

HR supine \_\_\_\_\_ sitting \_\_\_\_\_ standing \_\_\_\_\_