STONY BROOK SURGICAL ASSOCIATES
PEDIATRIC PATIENT ASSESSMENT FORM (new patients only)
Please complete all sections

PATIENT INFORMATION **HGT: _____WGT:_____ MRN#_____**
Name:_____ SS# _____ DOB_____/_____/_____
Address:_____
Tel # (h): _____Tel# (w):_____(cell #):_____
Name of Parent or Legal Guardian: _____
Address: ☐ Same as Patient ☐Different _____
Tel # (h): _____Tel# (w):_____(cell #):_____
Insurance Plan (primary):_____Ins #:_____
Insurance Plan (secondary):_____Ins #:_____
Is child included in plan? ☐ Yes ☐ No
Primary MD:_____Address:_____Tel#:_____
Doctor Who Referred You to Us: ☐ Same as Primary MD_____
Address:_____Tel#_____
Patient's Status: ☐ child ☐ Single ☐ Legally Married
Next of Kin/Contact Emergency Person:_____
Tel #: _____ Relationship: _____
Name of Pharmacy: _____ Tel #: _____

REASON FOR VISIT:_____
Do you have any pain related to your presenting complaint/condition? ☐ No ☐ Yes
(If yes, Pain Tool must be completed)

BIRTH HISTORY **WGT:_____** **PREMATURE:** ☐ NO ☐ YES _____wks
Complications: (describe) _____

HOSPITALIZATION/SURGERY/MAJOR ILLNESS ☐ **N/A**

PROBLEM	MTH/YEAR	WHERE TREATED	HOSPITAL DAYS

Blood Transfusion: ☐ No ☐ Yes Date:_____ ☐ Complications of Transfusion

MEDICATIONS (Please list all medications your child is currently taking, including vitamins & supplements)
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____
Herbal Medications? ☐ No ☐ Yes
Allergies to Medications? ☐ No ☐ Yes Type of Reaction? _____
Allergies to Food? ☐ No ☐ Yes Which?_____

GYNECOLOGIC/OBSTETRIC HISTORY ☐ **Not applicable**
Any pregnancies? ☐ No ☐ Yes How many children have you given birth to?_____
How many abortions or miscarriages? _____ Examine breasts monthly? ☐ No ☐ Yes
Date of Last period? _____ Lumps on breasts? ☐ No ☐ Yes

SOCIAL EXPOSURES
Alcohol ☐ No ☐ Yes Narcotics/Drug Use ☐ No ☐ Yes
Smokes Tobacco: ☐ No ☐ Yes # Yrs _____ # Packs/Day_____ When Stopped_____
Any recent exposures to contagious diseases? ☐ No ☐ Yes If yes, what? _____
Is your child or others exposed to second hand smoke inside or outside of home? ☐ No ☐ Yes
Is your child or you currently in a domestic violence situation? ☐ No ☐ Yes

NUTRITIONAL DATA
Is your child following a special diet? ☐ No ☐ Yes Type: _____
Is your child ? ☐ Breast Feeding ☐ On Infant formula (specify) _____ ☐ On Solids
Unintentional Weight Change : ☐ Over/Under 5 lbs in 1 month ☐ Over/Under 10 lbs in 3-6 months
Appetite: ☐ Good (eat 3+ meals/day) ☐ Fair (1-2 meals/day) ☐ Poor (less than 1 meal/day)

OVER PLEASE

MRN #:_____

PERSONAL/FAMILY HISTORY: (check all that apply for patient and/or family member)

	IF YES,	**PATIENT/WHEN/HOW OFTEN**	**FAMILY MEMBER/ RELATIONSHIP**
Abdominal Pain	☐	_____	☐_____
Anesthesia Problems	☐	_____	☐_____
Asthma	☐	_____	☐_____
Bleeding/Bruising Problems	☐	_____	☐_____
Bowel Problems	☐	_____	☐_____
Cancer	☐	_____	☐_____
Congenital Heart Disease	☐	_____	☐_____
Constipation	☐	_____	☐_____
Cough/Wheezing	☐	_____	☐_____
Diabetes Mellitus	☐	_____	☐_____
Ear Infections	☐	_____	☐_____
Ear Problems	☐	_____	☐_____
Eye Problems	☐	_____	☐_____
Genetic Disorder	☐	_____	☐_____
Headaches	☐	_____	☐_____
Heart Trouble	☐	_____	☐_____
Hepatitis	☐	_____	☐_____
Hernia – Inguinal/Umbilical	☐	_____	☐_____
Joint/ Limb Problems	☐	_____	☐_____
Kidney Problems	☐	_____	☐_____
Lung Disease	☐	_____	☐_____
Mental Retardation/Illness	☐	_____	☐_____
Hyperthermia/high temperature	☐	_____	☐_____
Moles that are changing?	☐	_____	☐_____
Nasal Problems	☐	_____	☐_____
Neurological Problems	☐	_____	☐_____
Rashes, Sores, Itching	☐	_____	☐_____
Seizure Disorder	☐	_____	☐_____
Skin Problems	☐	_____	☐_____
Sleep Problems	☐	_____	☐_____
Tonsil Infections	☐	_____	☐_____
Thyroid Problems	☐	_____	☐_____
Stomach Pain	☐	_____	☐_____
Urination Problems	☐	_____	☐_____
Weakness/Numbness	☐	_____	☐_____
OTHER _____	☐	_____	☐_____

☐ **CHECK IF NONE APPLY**

PERSONAL/SOCIAL HISTORY

Residence: ☐ Live with Parents ☐ Live Alone ☐ Shelter ☐ Other: _____

Can you read & understand English? ☐ Yes ☐ No What is your first language? _____

Religion: _____Race/Ethnicity:_____Preferred Language: _____

Interpreter Necessary: ☐ Yes ☐ No Occupation of Patient: ☐ Student ☐ Other _____

Cultural Beliefs that May Affect Care: ☐ No ☐ Yes _____

Religious Beliefs that May Affect Care: ☐ No ☐ Yes _____

Any barriers to learning (pls check): ☐ physical ☐ emotional ☐ vision ☐ hearing ☐ cognitive

Who will assist in child's care: ☐ Parent ☐ Family ☐ Legal Guardian ☐ Self ☐ Foster Agency ☐ Other

Specify (Name & Phone #): _____

COMPLETED BY:_____ ☐ Parent ☐ Patient DATE:_____

Print Name

REVIEWED BY:_____Provider Name & ID # DATE:_____

Sign Name and ID #