STONY BROOK SURGICAL ASSOCIATES

PEDIATRIC PATIENT ASSESSMENT FORM (new patients only)

Please complete all sections

Patient Information	HGT	WGT	SS#
Name (Last, First, MI)		MRN	DOB
Gender ☐Male ☐Female	Patient's Status ☐Child ☐Single ☐Legally Married		
Name of Parent or Legal Guardian		Relationship	
Home Phone	Work Phone	Cell Phone	
Name of Pharmacy		Phone	

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	YEAR	WHERE TREATED	DAYS IN HOSPITAL

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

Medications (Please list all medications you are currently taking, including vitamins and supplements)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Herbal medications? ☐No ☐Yes

Allergies to Medication? ☐No ☐Yes (type of reaction) _____

Food Allergies? ☐No ☐Yes (please specify) _____

Gynecologic/Obstetric History (ENT patients do not need to complete) ☐ N/A

Any Pregnancies? ☐No ☐Yes (how many) _____	How many children have you given birth to?_____
How many abortions/miscarriages? _____	Date of last period _____
Lumps on breasts? ☐No ☐Yes	Monthly breast exams? ☐No ☐Yes

Social Exposures ☐ N/A

Alcohol ☐No ☐Yes	Cocaine ☐No ☐Yes	Narcotics/Drug Use ☐No ☐Yes
Smokes Tobacco ☐No ☐Yes	If Yes, # of Yrs _____ # of Packs/Day_____ When Stopped_____	

Any recent exposure to contagious disease? ☐No ☐Yes (specify) _____

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

Personal/Social History

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

Who will assist in the patient's care ☐ Parent ☐ Family ☐ Legal Guardian ☐ Self ☐ Foster Agency
☐ Other (specify name and phone) _____

Can you read and understand English? ☐No ☐Yes	What is your first language? _____
Religion _____	Race/Ethnicity _____
Interpreter Necessary? ☐ Yes ☐ No	Patient's Occupation ☐ Student ☐ Other _____

Cultural & Religious Beliefs that May Affect Care ☐No ☐Yes _____

Do you have any barriers to learning? ☐ Physical ☐ Emotional ☐ Vision ☐ Hearing ☐ Cognitive

NAME_____
MRN# _____

Personal/Family History (Check all that apply for patient and/or family member)

IF YES	PATIENT/HOW OFTEN	FAMILY MEMBER/HOW OFTEN
Abdominal Pain	☐ _____	☐ _____
Anesthesia Problems	☐ _____	☐ _____
Asthma	☐ _____	☐ _____
Bleeding/Bruising Problems	☐ _____	☐ _____
Bowel Problems	☐ _____	☐ _____
Cancer	☐ _____	☐ _____
Congenital Heart Disease	☐ _____	☐ _____
Constipation	☐ _____	☐ _____
Cough/Wheezing	☐ _____	☐ _____
Diabetes Mellitus	☐ _____	☐ _____
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**		

Nutritional Data

Is your child/the patient following a special diet? ☐No ☐Yes _____
Is your child/the patient: ☐ Breast Feeding ☐ On infant formula (specify)_____ ☐ On Solids
Unintentional Weight ☐ 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)

COMPLETED BY: _____ DATE: _____

REVIEWED BY: _____ID # _____ DATE: _____