Children's Physician Group

INFECTIOUS DISEASES

PLEASE PRINT

Patient Name_____Appointment Date_____

Age_____Date of Birth_____ Referring Physician_____

Primary Care Physician_____ Physician Phone_____

Physician Address_____ Physician Fax_____

_____

Why is your child being referred?

_____

_____

_____

_____

Other healthcare providers your child has seen for this problem (List name and office number):

_____

_____

Medical History

Birth Weight_____Premature? ☐ Yes ☐ No (If yes, how many weeks)_____

Hospitalized in the nursery after birth? ☐ Yes ☐ No (If yes, how long)_____

Other Known Medical Problems/Diagnoses:

_____

_____

_____

_____

_____

Prior Hospitalizations (list dates/reason):

Date_____Reason_____

Date_____Reason_____

Date_____Reason_____

Date_____Reason_____

Date_____Reason_____

Prior Surgeries (list dates/reasons):

Date_____Reason_____

Date_____Reason_____

Date_____Reason_____

Allergies (list drug, food, etc, and the reaction your child has with the medicine):

_____

_____

Current Medication(s)

Medication(s)	Dose	How often

List the names of and reasons for any antibiotics taken in the past year

_____

_____

_____

_____

Are your child's immunizations up-to-date? ☐ Yes ☐ No ☐ Don't know

Family History

List any diseases that run in the family:

_____

_____

_____

Does anyone have:

Immune Problems or “low immunity” ☐ Yes ☐ No

Recurrent boils or skin infections ☐ Yes ☐ No

Other recurrent infections ☐ Yes ☐ No

Unusual infections: ☐ Yes ☐ No

Tuberculosis: ☐ Yes ☐ No

HIV infection: ☐ Yes ☐ No

Autoimmune or rheumatologic illness: ☐ Yes ☐ No

(e.g., lupus, rheumatoid arthritis inflammatory bowel disease):

Social History

List family members living in the home:

Name	Relation to the child	Age

Does your child attend out of home childcare? ☐ Yes ☐ No

Was your child born in the US?: ☐ Yes ☐ No

If NO, where:_____

Has your child ever traveled outside the US?: ☐ Yes ☐ No

If YES, please list location(s) and date(s):

_____

Has your child been exposed to someone with known tuberculosis (TB), or someone with chronic cough, weight loss, fevers, or who works in or has been in prison/jail or a nursing home?: ☐ Yes ☐ No

Do you have pets?: ☐ Yes ☐ No If YES, what kind?_____

Has your child been exposed to other animals?: ☐ Yes ☐ No

If YES, what kind? _____

Review of Systems:

Recently, or with this illness, has your child had:

Headache:	☐ Yes	☐ No	Cough:	☐ Yes	☐ No
Problems with vision:	☐ Yes	☐ No	Difficulty Breathing:	☐ Yes	☐ No
Earache:	☐ Yes	☐ No	Chest Pain:	☐ Yes	☐ No
Draining Ears:	☐ Yes	☐ No	Vomiting:	☐ Yes	☐ No
Red Eyes:	☐ Yes	☐ No	Diarrhea:	☐ Yes	☐ No
Runny Eyes:	☐ Yes	☐ No	Poor appetite:	☐ Yes	☐ No
Runny Nose:	☐ Yes	☐ No	Abdominal Pain:	☐ Yes	☐ No
Sore Throat:	☐ Yes	☐ No	Painful/burning urination:	☐ Yes	☐ No
Sores in the Mouth:	☐ Yes	☐ No	Painful bones, joints, or muscles:	☐ Yes	☐ No
Swollen Glands (nodes):	☐ Yes	☐ No	Swollen bones, joints, or muscles:	☐ Yes	☐ No
Rash or skin problems:	☐ Yes	☐ No	Weight loss:	☐ Yes	☐ No
Fever:	☐ Yes	☐ No			