

Lajes Field Family Health Clinic – Pediatric Visit

Name: _____

Date: _____

Date of birth: _____

Home phone number: _____

1. What is the reason for **today's visit**?

Cell phone number: _____

2. Who does the patient live with?

3. Is your family experiencing any current or upcoming military deployments?

4. Please rate your **pain level** on a scale of 0 (no pain) to 10 (severe pain): # ___ / 10.

<u>Medical History</u>	<u>Surgeries / Hospitalizations</u>	<u>Family History</u> <i>(list immediate family only)</i>
<input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Eczema <input type="checkbox"/> ADHD <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Seizures <input type="checkbox"/> Heart problems <input type="checkbox"/> Asthma <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Blood Clots <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Migraines <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	_____ (year: ____) _____ (year: ____) _____ (year: ____) _____ (year: ____)	Cancer (specify type) Heart attack or sudden death High blood pressure Diabetes High cholesterol

5. Did you fill out a separate **medication form**? Yes No (if not, please list current medications)

6. Check if you take: Vitamins Over-the-counter meds Supplements Herbals Weight loss meds

7. Please list any **allergies** you have (drug, food, latex): _____

8. **Tobacco** use: Never routinely used; Quit (year ____); Currently use: type and daily amount _____

9. Do you consume any **alcohol**? No Yes: Type? _____ How often? _____ Amount _____

10. Do you have any learning disabilities? No Yes (describe _____)

11. Is this visit deployment related? No Yes (when / where _____)

12. **Female questions:** Date of last menstrual period _____ Age of first menstrual period _____

Are you pregnant or suspect that you may be pregnant? No Yes

13. Do you see any **specialists**? If so, what type and for what condition(s)? _____

14. Over the past two weeks, how often have you been bothered by the following problems (**age 12 or older only**):

- a) Feeling down, depressed, or hopeless Not at all Rarely Multiple days Nearly everyday
- b) Thoughts of hurting myself or others Not at all Rarely Multiple days Nearly everyday
- c) Little interest or pleasure in doing things Not at all Rarely Multiple days Nearly everyday
- d) Feeling unsafe at home Not at all Rarely Multiple days Nearly everyday

15. In the past six months, have you experienced **unexpected** weight loss or recurring fevers No Yes

16. Is your sponsor on **PRP** status? No Yes (specify _____)

17. Do you have any cultural / religious practices that may impact care or education? (e.g. refusal of blood products or medications) No Yes

18. What is your preferred method of learning: Verbal Written Visual Other _____

19. Do you have an advanced directive? Yes No

20. Is this the first time you have been seen in the Lajes Family Health Clinic in the past 3 years? Yes No