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: ___________