

New Problem Visit Form – Child

Please complete every question (Use additional forms if necessary)

First Name

Last

Date:

Reason for visit/complaint:

When did it start (date) :

What makes it better:

What makes it worse:

Describe the symptoms: (i.e. Burning, painful, scratchy, sharp, throbbing, achy, hot, tingling)

Where are the symptoms located:

How often do you have these symptoms:

What caused these symptoms to occur:

Please list anything that you think may be connected to the problem:

Please list any additional symptoms that pertain to the reason for today's visit:

General: Fever Chills Fatigue Not happy Not playful Not eating Not drinking Headaches

Skin: Rash Spots Scabs Discharge from skin Red skin Swollen Itchy skin Increased sweating

Musculoskeletal: Joint stiffness Pain Weakness Cramping Decreased motion Swelling Muscle aches

Eyes: Red eyes Swollen eyes Watery eyes Discharge Lashes stuck together Yellow eyes Blurry Vision

Ears: Hearing loss Pain Discharge Ringing Room spinning

Nose: Clear nasal discharge Thick nasal discharge Congested/stuffy nose Bloody nose Decreased smell

Throat & Mouth: Sore throat Scratchy Hurts to swallow Swollen throat Swollen tonsils Hoarseness

Chest & Lungs: Cough Sputum Wheezing Shortness of breath Difficulty breathing with exertion

Heart & Blood Vessels: Chest pain Palpitations Difficulty breathing Leg swelling

Lymph Nodes: Enlarged Tender

Gastrointestinal: Indigestion Nausea Vomiting Constipation Diarrhea Dark stool Stomach pain

Genitourinary: Painful urination Back pain Urge to urinate Increased frequency Night time urination

Bloody urine Dribbling Decrease in force of stream Unable to control urine

Neuro: Fainting Weakness Loss of coordination Numbness Tingling Abnormal sensation Memory problems

Mood: Depressed Difficulty concentrating Nervous Anxious Tense Irritable Difficulty sleeping

Other:

Back office use only: Input by: