WCMC Department of Dermatology- Pediatric Patient Follow- up Intake Form

Patient Name: _____ **Date:** _____

Pediatrician Name (Family Practice Doctor): _____

Pediatrician Address/Phone: _____

Why are you here today? (Please specify area of body affected)

1. _____
2. _____
3. _____

Please complete the following information;

1. What is your child's current school grade (K-12)? _____

2. Are there pets in the home (dogs, cats, etc.)?_____ If **Yes**, what type _____

3. Are your child's immunizations up to date? Yes____ No____ If "**No**", what is outstanding? _____

4. Since your child's last visit, have there been any major illnesses, hospitalizations or emergency room visits?

Yes____ No_____

If you marked **"YES"** to question #4, which of the following problems exist? If "NO", please leave blank.

- ☐ Eyes
- ☐ Ears/ nose/ throat
- ☐ Chest/Lungs (Asthma)
- ☐ Heart
- ☐ Stomach
- ☐ Skin
- ☐ Urinary System
- ☐ Muscle/ bone
- ☐ Nervous System
- ☐ Psychiatric
- ☐ Blood/ Lymph nodes
- ☐ Allergies
- ☐ Routine exam
- ☐ Other (Please Specify)

_____

5. Are there any **MEDICATION or LATEX ALLERGIES**? Yes____ No____ If **Yes**, please specify

_____

6. Record all current medications. Include both prescribed and over the counter medicines and herbal treatments you are taking in the spaces below.

_____

_____

7. Are there any changes in family history since last visit? **Yes**____ **No**____ If **Yes**, please describe

_____

8. Wong- Baker pain scale

(Please circle one)

9. Are there any other special/ specific issues you wish to discuss during today's visit? Yes____ No____

If **Yes**, please describe _____

_____ _____

Guardian/ Parent/ Patient Initials **Provider Name (MD, NP, PA)**