WCMC Department of Dermatology- Pediatric Patient Exam Questionnaire

Patient Name: _____ **Today's Date:** _____

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

1._____

2._____

3._____

When did the problem(s) begin? _____

Please answer each of the following questions by checking off the appropriate box. Fill in explanation when necessary.

Social History

School-age/ Grade_____ Patient lives with: □ Both Parents □ One Parent □ Other_____

Exposed to second hand smoke? □ NO □ YES How much? _____

Sunscreen use? □ NO □ YES

Allergies

Does the patient have any **Allergies** to Medications? □ YES □ NO If **Yes** what are they? _____

If **Yes**, what type of reaction did the patient have? _____

Food Allergies? □ NO □ YES If **Yes**, what are they? _____

If **Yes**, what type of reaction did they have?_____

Any **other** types of **Allergies?** □ NO □ YES

If **Yes**, please describe _____

Skin

Has the patient ever had a skin biopsy? □ NO □ YES If **Yes**, when?_____ Biopsy Site?_____

Has the patient ever had skin cancer? □ NO □ YES If **Yes**, what type? _____

Abnormal looking skin moles? □ NO □ YES If **Yes**, where? _____

History of any skin diseases? □ NO □ YES If **Yes**, what? _____

Any **family** history of skin cancer? □ NO □ YES If **Yes**, who? _____What type? _____

Medicines

Is the patient taking any medications **(prescription or over-the-counter)** regularly now? □ NO □ YES

If **Yes**, complete the following:

Name of medication	**Reason for taking this**

Are all **Immunizations up-to date:** □ NO □ YES

Birth History (problems)? □ NO □ YES If **Yes,** please describe_____

Operations/Hospitilization

Has the patient ever been **hospitalized?** □ NO □ YES

If **Yes**, complete the following:

Date of hospitalization	**Reason for hospitalization**

Review of Systems

Does the **child** have **any** of the following complaints?

General

Fatigue	□ NO	□ YES
Weight loss	□ NO	□ YES
Weakness	□ NO	□ YES
Swollen Lymph nodes	□ NO	□ YES
Easy bruising	□ NO	□ YES
Fever	□ NO	□ YES

Head

Visual problems	□ NO	□ YES
Ear pain, decreased hearing	□ NO	□ YES
Difficulty swallowing	□ NO	□ YES
Strokes	□ NO	□ YES
Ear/Nose/ Throat Problems	□ NO	□ YES

If **Yes**, explain: _____

Chest, Heart & Lungs

Shortness of breath	□ NO	□ YES
Frequent cough	□ NO	□ YES
Asthma	□ NO	□ YES
Heart Disease	□ NO	□ YES

Other (Please Specify) _____

_____

Gastrointestinal

Poor appetite/feeding	□ NO	□ YES
Vomiting	□ NO	□ YES
Change in bowel habits	□ NO	□ YES
Pass blood from rectum	□ NO	□ YES
Reflux (gastro-intestinal) / Stomach Problems	□ NO	□ YES

Skin

Warts: Location_____	□ NO	□ YES
Keloids: Location_____	□ NO	□ YES
Acne: Location_____	□ NO	□ YES
Eczema: Location_____	□ NO	□ YES
Psoriasis: Location_____	□ NO	□ YES

Other, please specify: _____

Endocrine

Thyroid condition	□ NO	□ YES
Diabetes	□ NO	□ YES

Other (Please describe) _____

Genitalia (Female Only)

Abnormal Periods	□ NO	□ YES
Vaginal Discharge or spotting (not from period)	□ NO	□ YES
Adolescent female, Indicate if pregnant:	□ NO	□ YES

Male Only

Discharge from penis	□ NO	□ YES
Sore on penis	□ NO	□ YES

Other _____

Neuromuscular

Weakness in arms or legs	□ NO	□ YES
Dizzy/ Fainting spells	□ NO	□ YES
Seizures	□ NO	□ YES

Other (Please Specify) _____

Kidney Problems

□ NO □ YES

If yes, explain _____

Bones/Joints

Painful or swollen joints	□ NO	□ YES
Loss of muscle strength	□ NO	□ YES
Arthritis joints	□ NO	□ YES

Other _____

Other Medical Problems

Blood Disorder	□ NO	□ YES
Bleeding problems	□ NO	□ YES
HIV/AIDS	□ NO	□ YES
Cancer	□ NO	□ YES
Growth/Development problems	□ NO	□ YES
ADHD	□ NO	□ YES
Depression/Anxiety	□ NO	□ YES

Other: _____

Are there any other problems or concerns? (Please Describe)

_____

_____ _____

Physician's Signature **Date**

Weill Cornell Medical College

NewYork-Presbyterian
Weill Cornell Medical Center

Please provide us with the following information

Pediatric Physician Information

Pediatrician Name: _____

Address: _____

_____

Telephone number: _____

Fax Number: _____

If the Referring physician is different from your Pediatrician, please complete the information in the box below.

Referring Physician's Information

Referring Physician Name: _____

Address: _____

_____

Telephone: _____

Fax Number: _____

Does your Insurance plan require referrals for specialty visits? Yes____ No____

If **Yes**, Do you have a referral for today's visit? Yes____ *****No____

*** Please Note that if a valid insurance referral is not received for today's visit, you may be responsible for all charges incurred.**