Platte Valley Medical Group

Date_____

Pediatric 0-12 years

Name_____ **DOB** ___/___/___

Primary Care Physician_____ **Referring Physician**_____

List all medication prescription and nonprescription

Primary Pharmacy_____ **No Medications**_____

Medications	**Medication Dose**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

Medication Allergies

Medication	**Reaction** (hives, nausea, vomiting, etc.)
o _____	_____
o _____	_____
o _____	_____
o _____	_____

Past Medical History

(Closest date of diagnosis if known)

o	Abdominal pain __/__/___	Diabetes __/__/___	Pyelonephritis __/__/___
o	Acne __/__/___	Eczema __/__/___	Seizure disorder __/__/___
o	ADD __/__/___	Fracture __/__/___	(type)_____
o	ADHD __/__/___	(site)_____	Urinary Infections__/__/___
o	Allergies __/__/___		Other _____
o	Anemia __/__/___	GERD __/__/___	Other_____
o	Asthma __/__/___	Head injury __/__/__	Other_____
o	Birth trauma __/__/___	Headache/	
o	Bleeding disorder__/__/__/___	Migraines __/__/___	Disorders: examples
o	Bronchitis __/__/___	Menstrual problems	(bipolar, behavior, cognitive)
o	Chickenpox __/__/___	__/__/___	Other_____
o	Concussion __/__/___	Otitis media __/__/___	Other _____
o	Congenital Heart	Pneumonia __/__/___	Other_____
	Disease __/__/___	Prematurity __/__/___	Other _____

Pediatric Surgical History

- o Adenoidectomy ___/___/___
- o Appendectomy ___/___/___
- o Blood transfusion ___/___/___
- o Dental surgery ___/___/___
- o Hernia repair ___/___/___
  (Inguinal)
  (Umbilical)

Arthroscopy Knee R)__ L)__ ___/___/___
Open Reduction Internal Fixation (ORIF)
Which limb R)__L)__ ___/___/___
Other_____
Other_____
Other_____

Immunizations 0-18 years

Hepatitis B ___/___/___ Polio___/___/___(IPV) HIB ___/___/___ Dtap, ___/___/___

Hepatitis A ___/___/___ Influenza___/___/___ MMR __/___/___ Varicella ___/___/___

Rotovirus ___/___/___ HPV ___/___/___

Pneumococcal (Prevnar) ___/___/___ Meningococcal ___/___/___

New patients please have consent form signed for release of Medical History from previous Medical Clinics.

Please bring the forms with you to your appointment. Thank you.