Floating Hospital for Children at Tufts Medical Center

Staff:
Place patient ID sticker here

FOOD ALLERGY CENTER
NEW PATIENT VISIT

Date: _____

Please fill out the following information on this form.

Child's Name: _____

Address: _____

_____

Phone: _____

Tufts M.C. Unit Number: _____

Site of Clinic Visit: _____

Date of Birth: _____

State of Birth: _____

First Parent

Name: _____

Address (if different from that of child):

_____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Fax: _____

Occupation: _____

Second Parent

Name: _____

Address (if different from that of child):

_____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Fax: _____

Occupation: _____

Pediatrician: _____

Address: _____

_____

Phone: _____

Fax: _____

Referring MD Name: _____

Address: _____

Insurance Company: _____

Subscriber Name: _____

Ins. Policy Number: _____

Pharmacy Name & Town: _____

Pharmacy Phone Number: _____

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Please help us care for your child and your family by filling out this form.

HISTORY OF PRESENT ILLNESS:

Why is your child here to see us today?

_____

_____

_____

This section is for clinician use only.

HPI:

Does your child complain of abdominal pain?

- ❑ No
- ❑ Yes

How long ago did the pain begin? *Please fill in the appropriate number of days, weeks, months, or years.*

____ Days ___ Weeks _____ Months _____ Years

How often does the pain come back? *Please check the appropriate time frame.*

_____ Daily or Intermittently

_____ Weekly

_____ Monthly

How long does the pain last? *Please check the appropriate time frame.*

_____Seconds _____ Minutes _____ Hours _____ Days

Describe the pain: _____

_____

Location of the pain
Please circle all that apply.
You are looking at your child's belly from the front.
"5" is the belly button.

[R] 1 2 3 4 5 6 7 8 9 [L]

Does it interrupt play/activity? ❑Yes ❑No

Does it interrupt sleep? ❑Yes ❑No

Is it relieved by food? ❑Yes ❑No

Is it relieved by bowel movements? ❑Yes ❑No

What makes it feel better/go away? _____

_____

_____

Does your child vomit or spit up?

- ❑ No
- ❑ Yes

Is it painful? ❑Yes ❑No

Does it dribble out slowly? ❑Yes ❑No

Does it shoot out? ❑Yes ❑No

Is there blood? ❑Yes ❑No

What color is it? _____

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Does your child have problems swallowing?

- ❑ No
- ❑ Yes

Which does your child have trouble with?

❑ Solids ❑ Liquids ❑ Both

How many bowel movements does your child have?

Each day_____Each week_____

How many are liquid? _____

Are some formed or hard? ❑Yes ❑No

Do you see blood? ❑Yes ❑No

Does your child strain to pass a bowel movement? ❑Yes ❑No

Does your child soil his/her underwear? ❑Yes ❑No

MEDICAL HISTORY:

What medical problems have you been told that your child has?

_____

_____

_____

_____

_____

Has your child ever stayed overnight in the hospital? ❑Yes ❑No

Has your child ever had an operation? ❑Yes ❑No

If YES, *please provide more information below.*

When Where Why

_____

_____

_____

Has your child's growth been normal?

❑Yes ❑No If NO, *please describe.*_____

_____

Has your child's development been normal?

❑Yes ❑No If NO, *please describe.*_____

_____

Birth history:

Were there any problems with the pregnancy? ❑Yes ❑No

Were there any problems with labor? ❑Yes ❑No

Were there any problems with delivery? ❑Yes ❑No

Was your child premature? ❑Yes _____ weeks ❑No

What was your child's birth weight? ___lb _____ oz _____ gm

What was your child's birth length? _____ in

_____ cm

Are your child's immunizations up-to-date?

- ❑ No
- ❑ Yes

This section is for clinician use only.

PMH/PSH:

BIRTH HX:

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MEDICATIONS:

What medicines does your child take? *Please include any over-the-counter medicines, vitamins, etc.*

Name Dose How often

_____
_____
_____
_____
_____
_____

Does your child take any **complimentary medicines** (for example probiotics, vitamins, supplements, etc)?

_____
_____
_____
_____

ALLERGIES:

Is your child allergic to any medications or food?

- ❑ No
- ❑ Yes

Medications: _____
_____
_____

Food: _____
_____

What type of reaction did he/she have? _____
_____

This section is for clinician use only.

MEDS:

ALLERGIES:

ROS:

REVIEW OF SYSTEMS:

*Please check **if** your child has had any of the following:*

- ❑ weight loss
- ❑ fevers
- ❑ tiredness
- ❑ excessive sweating
- ❑ change in appetite
- ❑ growth delays
- ❑ painful urination
- ❑ urinary leakage
- ❑ blood in urine
- ❑ rash
- ❑ itchy skin
- ❑ Recent change of vision
- ❑ sore throat
- ❑ nasal discharge
- ❑ heat/cold intolerance
- ❑ hearing loss
- ❑ mouth sores
- ❑ depression
- ❑ headaches
- ❑ choking
- ❑ chest pain
- ❑ palpitations
- ❑ trouble breathing
- ❑ wheezing
- ❑ cough
- ❑ large lymph nodes
- ❑ easy bruising
- ❑ joint/muscle pain
- ❑ swollen joints

Other: _____
_____
_____
_____

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SOCIAL HISTORY:

What grade is your child in at school? _____

If your child is in school, how many days of school has your child missed in the past month? _____

How is your child doing in school? ❑Above average ❑Average ❑Below average

Does your child smoke, or does anyone living at home smoke? ❑Yes ❑No

Does your family/your child travel outside the United States?

❑Yes ❑No If YES, where and when _____

_____

Is there stress at home? ❑Yes ❑No

Please check any that apply.

- ❑ Parents separated
- ❑ Parents divorced
- ❑ Recent move
- ❑ Recent death in family
- ❑ New school

Other _____

_____

This section is for clinician use only.

SOC HX:

FAM HX:

FAMILY HISTORY:

Names and ages of brothers and sisters:

_____

_____

_____

Mother's Date of Birth: _____

Mother's Adult Height:_____ft' in" Weight: __lbs oz _____ kg

Father's Date of Birth: _____

Father's Adult Height:_____ft' in" Weight: __lbs oz _____ kg

Does anyone in the family (brothers, sisters, parents, grandparents, etc) suffer from any of the medical problems listed below?

			Relationship to your child & age at diagnosis
Crohn's disease	❑Yes	❑No	_____
Ulcerative colitis	❑Yes	❑No	_____
Stomach ulcers	❑Yes	❑No	_____
Reflux/heartburn	❑Yes	❑No	_____
Bowel polyps	❑Yes	❑No	_____
Colon cancer	❑Yes	❑No	_____
Bowel surgery	❑Yes	❑No	_____
Jaundice	❑Yes	❑No	_____
Hepatitis	❑Yes	❑No	_____
Liver disease/cirrhosis	❑Yes	❑No	_____
Gallstones	❑Yes	❑No	_____
Pancreatitis	❑Yes	❑No	_____

Irritable bowel	❑Yes	❑No	
Environmental allergies	❑Yes	❑No	_____
Food allergies	❑Yes	❑No	_____
Asthma	❑Yes	❑No	_____
Cystic fibrosis	❑Yes	❑No	_____
Autoimmune disorders	❑Yes	❑No	_____
Celiac disease	❑Yes	❑No	_____
Diabetes	❑Yes	❑No	_____
Thyroid problems	❑Yes	❑No	_____
Arthritis	❑Yes	❑No	_____
Bleeding problems	❑Yes	❑No	_____
Anesthesia problems	❑Yes	❑No	_____

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What are the child's and parents' racial and ethnic backgrounds? *Please place a check mark where appropriate.*

	Child	Mother	Father
Black, not of Hispanic Origin			
Hispanic			
Asian/Pacific Islander			
Caucasian			
Unknown			
Prefer not to answer			
Other – please describe			

Has your child had any blood work, x-rays, or other types of procedures done? ❑Yes ❑No

If YES, *please provide more information below if possible.*

What When Where Why

_____
_____
_____
_____
_____
_____

Has another other health care provider checked your child, or provided care to your child for today's illness/problem(s)?
❑Yes ❑No

If YES, who: _____
_____
_____
_____

May we contact him/her? ❑Yes ❑No

This section is for clinician use only.

❑ REVIEWED PREVIOUS STUDIES

Home environment

Please check all the boxes that describe your environment.

□ feather pillows □ down comforter □ carpet on bedroom floor □ dust proof mattress cover
Type of mattress: □ box spring/regular □ water □ foam □ other _____
□ Cat(s) □ Dog(s) □ Cat or Dog go into the bedroom
□ other pets (list) _____
Air conditioning □ None □ Central □ Window
Humidifier □ None □ Central □ single room unit
Type of heating □ Forced hot water □ Forced hot air □ electric baseboard
□ Visible mold, mildew or dampness in your home Location _____
□ Evidence of cockroaches

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This page is to be completed by the clinician.

DATE:_____ PT'S AGE:_____

VS: BP: _____ T: _____ P: _____

RR: _____ HC: _____ cm BMI: _____

WEIGHT: _____ lbs _____ kg _____ %ile

HEIGHT: _____ ins _____ cm _____ %ile

PHYSICAL EXAMINATION:

General: _____

Eyes: ❑ nl _____
HENT: ❑ nl _____
Neck: ❑ nl _____
Lungs: ❑ nl _____
Heart: ❑ nl _____
GU: ❑ nl _____
Tanner Stage: I II III IV V
Joints: ❑ nl _____
Neuro: ❑ nl _____
Derm: ❑ nl _____

Abdomen:
Tenderness ❑ nl _____
Organomegaly ❑ nl _____
Masses ❑ nl _____

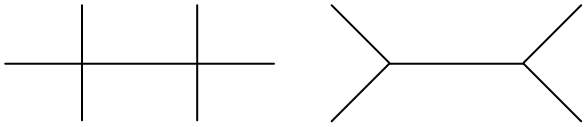
Rectal: External ❑ nl _____
Tone ❑ nl _____

Stool: _____
Guaiac: ❑ positive ❑ negative ❑ not done

Comments: _____

_____

PREVIOUS LABS/EVALUATIONS/PROCEDURES: _____



_____

_____

IMPRESSION (Differential Diagnosis)**:** _____

_____

_____

PLAN: _____

_____

_____

COUNSELING TIME: _____ mins ❑ **DICTATED**

_____ _____
Signature DATE

I reviewed and confirmed the history with the family and performed the key parts of the physical examination. Key findings include:

_____.

I agree with the differential diagnosis and plan of care outlined above.