PRIMARY CARE SPECIALISTS OF FLORIDA

721 W COLONIAL DR, ORLANDO, FL 32804

Tel: (407) 735-6735, Fax: 1-855-618-2347

PEDIATRIC CLINICAL SUMMARY (Age 0 to 17)

Please update any changes since your last visit here

Patient Name: _____ **Date:** _____

Brought in by: _____

What is the reason for today's visit?

_____

_____

Please check if your child has recently or frequently had:

Allergy
□ rhinitis
□ persistent congestion
□ hives
□ eczema, dermatitis
□ asthma

Cardiovascular □ chest pain
□ heart murmur
□ trouble exercising
□ irregular heart beat

Constitutional
□ fever
□ tiredness
□ unexplained weight loss
□ slow growth

Ear, Nose, Throat
□ earache
□ drainage from ear
□ hearing problem □ nasal congestion
□ nose bleeds
□ throat pain
□ hoarseness

Endocrine
□ excessive thirst
□ too fat
□ too thin
□ slow growth
□ lack of energy
□ excessive growth

Eyes
□ poor vision
□ red eyes
□ eye pain

Gastrointestinal
□ vomiting
□ diarrhea
□ constipation
□ blood in stools
□ abdominal pain
□ trouble eating or feeding

Genitourinary
□ painful urination
□ frequent urination
□ blood in urine
□ bed wetting

Hematology
□ bruising easily
□ bleeding frequently
□ low blood count
□ anemia

Musculoskeletal
□ back pain
□ joint pain
□ limp
□ bad posture
□ muscle soreness

Neurological
□ headache
□ developmental delay
□ clumsiness
□ seizures
□ dizziness
□ unusual head shape

Psychiatric
□ depressed
□ overactive
□ fearful
□ angry
□ oppositional
□ thoughts of death
□ thoughts of suicide

Respiratory
□ trouble breathing
□ coughing
□ wheezing

Skin
□ new lumps
□ black moles
□ itching
□ rash

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Parent(s) with whom child lives majority of time:
Father Mother Step Father Step Mother Foster Parent Grandparent Relative

Above father's name and occupation: _____

Above mother's name and occupation: _____

Who is the child's legal guardian? Parent(s) _____ Other _____

Names and birth year of brothers and sisters: _____

_____

Who cares for the child during the daytime? _____

Grade at school: _____ **Is school performance acceptable?** _____

Any special diet or special nutrition supplements? _____

Birth History: Birth weight _____ length _____ Head Circ _____ Gestational age ____wks

Please list any chronic or frequent medical problems and any past surgery:

_____ _____
_____ _____
_____ _____

Medications used frequently:

_____
_____

Does anyone in the house smoke? Yes No

Please indicate if any diseases affect other family members:

□ tuberculosis □ diabetes □ Other (please explain)
□ asthma □ seizures
□ hypertension □ mental illness
□ heart disease □ sickle cell disease

PLEASE ATTACH IMMUNIZATION RECORD
PLEASE ATTACH BIRTH RECORDS AND PAST MEDICAL RECORDS