Patti C. Huang, M.D., PA

Child Patient Information

Main Reason for today's visit: _____

Today's Date: / /	Primary Care Physician:	Referred to us by:	
Patient's Name:		Parent's Email:	
Birth Date: / /	Sex:	Who does this child live with (mother, father, Grandpa, etc.)?	
Street Address:	City:	State:	Zip Code:
Parent's Employer: Occupation:	Parent's Work#:	Parent's Home#:	Parent's Cell#:
Emergency Contact:	Relationship to Patient:	Phone#	
Name of Primary Insurance	Policy Holder : Birth Date: / / SS#: -- --	Relationship to Patient Self/Spouse/Child	
Name Secondary Insurance	Policy Holder : Birth Date: / / SS#: -- --	Relationship to Patient Self/Spouse/Child	

Does your child attend daycare/preschool? Yes No
And if so, where?

Pharmacy Name & Location
(Please name the cross streets and city of your most frequented pharmacy)

Personal Heath History

Please list any medical diagnoses received from other healthcare providers:

Drug Allergies & Nature of Allergic Reaction:

Medications (Rx and Non-Rx):	Surgeries/Hospital Admissions & Dates:

Notes for Rx filled in by Dr. Huang:

_____

_____

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Health Habits	
Exercise	○ Sedentary (no exercise) ○ Mild Exercise (i.e. climbing stairs, walking 3 blocks, playing golf) ○ Occasional vigorous exercise (i.e. less than 4x/week for 30 min) ○ Regular vigorous exercise (i.e. 4x/week for 30 min)
Caffeine	Does the child consume and caffeinated beverages? If so, what kind? To what extent? i.e. 1xdaily, 2xweekly
Tobacco	Is the child exposed to second-hand smoke? If so, to what extent? i.e. 1xdaily, 2xweekly, etc.

Family Medical History (Please specify where illness has occurred in your family)					
Allergies	Mother	Father	Both	Neither	Other:
Anesthesia Complications	Mother	Father	Both	Neither	Other:
Asthma	Mother	Father	Both	Neither	Other:
Arthritis	Mother	Father	Both	Neither	Other:
Cancer	Mother	Father	Both	Neither	Other:
Cardiovascular Issues: Hypertension and/or Stroke	Mother	Father	Both	Neither	Other:
Diabetes	Mother	Father	Both	Neither	Other:
Hearing Loss	Mother	Father	Both	Neither	Other:
Mental Illness	Mother	Father	Both	Neither	Other:
Obesity	Mother	Father	Both	Neither	Other:
Osteoporosis	Mother	Father	Both	Neither	Other:

Current Symptoms (Please circle any current symptoms your child is having and mark through those he/she are not experiencing)				
Allergy	Runny Nose	Scratchy Throat	Ear fullness	Stuffy Nose
	Sinus Congestion	Itchy Eyes		
Cardiology	Chest Pain	Heart Murmur	Shortness of Breath	Elevated Blood Pressure
Ears	Ear drainage	Ringing	Balance Problems	Hearing Problems
Eyes	Blurry Vision	Double Vision	Spotted Vision	
Gastrointestinal	Vomiting	Nausea	Constipation	Blood in Stool
	Diarrhea	Heartburn		
Musculoskeletal	Joint Pain	Stiffness	Chronic soreness	
Neurologic	Headache	Tingling/Numbness	Seizures	Migraine
Nose	Excessive Sneezing	Nasal itching	Watery eyes	Nasal Obstruction
	Loss of smell	Snoring		
Psychiatric	Depression	Anxiety	Panic Attacks	
Respiratory	Wheezing	Coughing	Chest congestion	Recent Bronchitis
Throat	Difficult or painful swallowing	Sore throat	Hoarseness	