PATIENT HISTORY

After Hour Pediatrics
URGENT CARE +

210 Baldwin Avenue. San Mateo, CA 94401.
Phone (650) 579-6581 Fax (650) 579-7581

Name, DOB, M/F _____

Phone 1._____ 2. _____

Physician _____

Date of Visit _____

Patient Age _____ Time _____

CC

_____

_____ _____
Receptionist Initials

REASON FOR VISIT

_____

_____

Onset ❑ Hours___ ❑ Days___ ❑ Weeks___
Severity ❑ Mild ❑ Moderate ❑ Severe
Condition ❑ Constant ❑ Intermittent ❑ Improving ❑ Worsening

Better with _____

Worse with _____

If pain: ❑ Dull ❑ Sharp ❑ Achy ❑ Crampy ❑ Throbbing
If injury, occurred at ❑ Home ❑ School ❑ Public ❑ Private Location

Current Medications: _____
Medicine *Time of last dose*

_____
Medicine *Time of last dose*

Allergies: ❑ No ❑ Yes_____
(Medication)
❑ Yes_____
(Environmental/food)

During day is patient: is primarily at ❑ Home ❑ Day Care ❑ School

Has patient been exposed to anyone with similar symptoms?

❑ No ❑ Yes (who?)_____

Has patient been exposed to Second Hand Smoke? ❑ No ❑ Yes

FAMILY HISTORY

What medical conditions run in your immediate family?

❑ Asthma ❑ Allergies ❑ Autism ❑ Intestinal ❑ Eczema ❑ Ear Infections
❑ Cancer ❑ Headaches ❑ Croup ❑ Neurologic ❑ Diabetes ❑ Kidney/UTI
❑ Heart disease ❑ Other_____
❑ Family History – negative (except as indicated above)

OTHER CONCERNS / ROS

Does patient have other problems or concerns?

No Yes

❑ ❑ Head: headache light-headed dizzy seizure
❑ ❑ Eyes: red itchy painful discharge swollen
❑ ❑ Ears/Nose/Throat: pain congestion sneezing bleeding
❑ ❑ Neck: stiff sore swollen glands
❑ ❑ Heart: palpitations fast heart rate
❑ ❑ Lungs: dry moist barky cough wheezing rapid breath
❑ ❑ Abdomen: vomit diarrhea pain constipation w/ blood
❑ ❑ Skin: rash itchy burn cut dry hives eczema blisters
❑ ❑ Muscle/Bones pain broken weak achy swollen
❑ ❑ Genital/Urinary burning frequency urgency rash
❑ ❑ Fever? If yes, how high? _____
❑ ❑ Other Problems_____

CONSENT / FOLLOW UP INFORMATION

For follow-up, such as lab results, X-Ray reports, or billing matters, I prefer AHP to notify me by phone or email at:

_____

If AHP cannot reach me by phone, I authorize AHP to leave a detailed message about the care of the patient. I certify that the above information is true and I consent to any medical or surgical treatment rendered to the patient under the general or special instructions of the physician. I understand I may review in detail AHP's Privacy Practices. I am aware of my right to request special privacy considerations.

Signature of ❑ Mother ❑ Father ❑ Grandparent ❑ Adult Parent/Guardian X_____

PAST, RECURRING OR CHRONIC CONDITIONS

No Yes

❑ ❑ Hospitalizations?_____
❑ ❑ Operations?_____
❑ ❑ Neuro/Behavioral _____
❑ ❑ Autism _____
❑ ❑ Developmental_____
❑ ❑ Emotional_____
❑ ❑ Eyes/Ear/Throat _____
❑ ❑ Breathing/Lungs _____
❑ ❑ Heart _____
❑ ❑ Abdomen _____
❑ ❑ Urine/Kidney _____
❑ ❑ Genital/STD/LMP _____
❑ ❑ Skin _____
❑ ❑ Other _____

Birth History: Wgt. _____Problems?_____

Date of last physical/well care visit_____

Vaccines current? ❑ No ❑ Yes Flu Vaccine? ❑ No ❑ Yes

PLEASE DO NOT WRITE BELOW THIS LINE Rev 6/26/18

❑ History reviewed by RN/MA_____

❑ Allergies noted by RN/MA_____ ❑ NKDA

PROVIDER SUMMARY OF ROS/PMH

❑ All ROS negative except as noted.

❑ Family History non-contributory except as noted.

_____

_____

_____

_____

❑ Hx reviewed and verified by MD/NP_____