

WCMC Department of Dermatology- Pediatric Patient Follow-up Intake Form

Patient Name: _____

Date: _____

Pediatrician Name (Family Practice Doctor): _____

Pediatrician Address/Phone: _____

Why are you here today? (Please specify area of body affected)

1. _____
2. _____
3. _____

Please complete the following information;

1. What is your child's current school grade (K-12)? _____
2. Are there pets in the home (dogs, cats, etc.)? _____ If **Yes**, what type _____
3. Are your child's immunizations up to date? Yes ___ No ___ If "**No**", what is outstanding? _____
4. Since your child's last visit, have there been any major illnesses, hospitalizations or emergency room visits?
Yes ___ No ___

If you marked "**YES**" to question #4, which of the following problems exist? If "**NO**", please leave blank.

- | | |
|---|---|
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Ears/ nose/ throat |
| <input type="checkbox"/> Chest/Lungs (Asthma) | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Urinary System | <input type="checkbox"/> Muscle/ bone |
| <input type="checkbox"/> Nervous System | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Blood/ Lymph nodes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Routine exam | <input type="checkbox"/> Other (Please Specify) |

5. Are there any **MEDICATION** or **LATEX ALLERGIES**? Yes ___ No ___ If **Yes**, please specify _____

6. Record all current medications. Include both prescribed and over the counter medicines and herbal treatments you are taking in the spaces below.

7. Are there any changes in family history since last visit? Yes ___ No ___ If **Yes**, please describe _____

8. Wong- Baker pain scale



(Please circle one)

9. Are there any other special/ specific issues you wish to discuss during today's visit? Yes ___ No ___

If **Yes**, please describe _____

Guardian/ Parent/ Patient Initials

Provider Name (MD, NP, PA)