PINNACLE
Family Health Care

Provider: Sasipha "Kate" Pahamark (Family Nurse Practitioner)
2781 Washington Drive, Suite 101, Norman, OK 73069
TEL: (405) 857-8880 FAX: (405) 279-0285
E-MAIL: clocke@pinnaclefhc.com

New Patient Sick Visit (Ages 17 Years & Under)

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____ **Biological Sex:** ☐ **Male** ☐ **Female**

REASON FOR VISIT TODAY:

_____

_____

Name of Legal Guardian accompanying the patient during today's visit: _____

Relationship: _____

Is the patient currently experiencing any of the following problems or symptoms?

- ☐ Fever or chills
- ☐ Poor Appetite
- ☐ Weight Loss
- ☐ Headaches
- ☐ Trouble swallowing
- ☐ Mouth Sores
- ☐ Runny Nose
- ☐ Snoring
- ☐ Decreased hearing/ringing in ears
- ☐ Ear Pain
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling
- ☐ Nausea or vomiting
- ☐ Heartburn or indigestion
- ☐ Abdominal pain
- ☐ Diarrhea or constipation
- ☐ Blood in the stool or black stools
- ☐ Rectal pain
- ☐ Change in bowel movements
- ☐ Gas or belching
- ☐ Involuntary loss of urine
- ☐ Pain/burning with urination
- ☐ Blood in Urine
- ☐ Neck or back pain
- ☐ Pain, swelling, or stiffness in joints
- ☐ Muscle pain
- ☐ Dizziness
- ☐ Weakness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness or tingling
- ☐ Speech Difficulties
- ☐ Trouble Sleeping
- ☐ Feel tired all the time
- ☐ Feel nervous, tense, or stressed
- ☐ Feel depressed
- ☐ Increased thirst or urination
- ☐ Hot/Cold Intolerance
- ☐ Skin rashes
- ☐ Sneezing or itchy watery eyes
- ☐ Thumb sucking
- ☐ Nail biting

FEMALES ONLY:

- ☐ Discharge from breast
- ☐ Vaginal discharge/bleeding
- ☐ Vaginal pain

MALES ONLY:

- ☐ Testicular swelling or pain
- ☐ Penile rash or discharge
- ☐ Penile pain

ALLERGIES: ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date

CURRENT MEDICATIONS: *(include prescription, over the counter, and supplements.)* or ☐ **NONE**

Name of medication	Dose	How often taken	Reason for taking medication	Prescriber

PREVIOUS HOSPITALIZATIONS: *(include all non-surgical hospitalizations)* or ☐ **NONE**

Reasons for Hospital Stay	Approximate Date	Hospital Name

SURGERIES or ☐ **NONE**

Type of Surgery	Approximate Date	Hospital & Surgeon Name

PATIENT'S PERSONAL MEDICAL HISTORY: *(please select all that apply)*

☐ Abdominal pain
☐ Acne
☐ ADD/ADHD
☐ Anemia
☐ Allergies
☐ Allergic Rhinitis
☐ Asthma
☐ Autism
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer: _____
☐ Cardiovascular Disease
☐ Chickenpox
☐ Congenital Heart Disease
☐ Constipation
☐ Concussion
☐ Deafness
☐ Depression
☐ Developmental Delay
☐ Dislocation of Hip
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Ear infection
☐ Eating Disorder
☐ Eczema
☐ Elevated lipids/Cholesterol
☐ Fainting
☐ Food Allergy
☐ Fracture
☐ Genetic Disorder
☐ Growth/Weight Problems
☐ Headaches
☐ Head injury
☐ Hearing Problems
☐ Heart Murmur
☐ History of Wheezing
☐ High Blood Pressure
☐ Inhaler/Neb Use
☐ Learning Impairment
☐ Migraines
☐ Otitis Media, Recurrent
☐ Overweight/Obesity
☐ Pneumonia
☐ Prematurity
☐ Psychiatric problems
☐ Pyelonephritis
☐ Kidney Problems
☐ Scoliosis
☐ Seizures
☐ Sickle Cell
☐ Speech Delay
☐ GERD/Acid Reflux
☐ Strabismus/Eye Problems
☐ Thyroid Disease
☐ Underweight
☐ Urinary Tract Infection
☐ Vision Problems
☐ Other: _____
_____
_____

PATIENT'S FAMILY HISTORY: or ☐ **UNKNOWN / ADOPTED**

Is there a family history of:	YES	NO	Relationship	Age of Onset	Living (Age)	Deceased (Age)
ADD/ADHD	☐	☐				
Allergies	☐	☐				
Asthma	☐	☐				
Birth Defects	☐	☐				
Cancer	☐	☐				
Cardiovascular Disease	☐	☐				
Coronary Artery Disease	☐	☐				
Deafness	☐	☐				
Depression	☐	☐				
Developmental Dislocation of Hip	☐	☐				
Diabetes Type 1	☐	☐				
Diabetes Type 2	☐	☐				
Eczema	☐	☐				
Elevated Lipids / Cholesterol	☐	☐				
Eye Problems	☐	☐				
Genetic Disease	☐	☐				
Heart Attack	☐	☐				
Hemoglobinopathy / Sickle Cell	☐	☐				
High Blood Pressure	☐	☐				
Kidney Disease	☐	☐				
Learning Impairment	☐	☐				
Mental Health Problems	☐	☐				
Migraines	☐	☐				
Obesity / Overweight	☐	☐				
Scoliosis	☐	☐				
Seizure Disorder	☐	☐				
Stroke	☐	☐				
Sudden Infant Death Syndrome	☐	☐				
Thyroid Disease	☐	☐				
Other: _____						

PATIENT'S BIRTH HISTORY:

Place of birth: _____ **Birth weight:** _____ **lbs.** _____ **oz.**

Duration of pregnancy: _____ **weeks** **Mother's Age:** _____ **Father's Age:** _____

Problems with pregnancy? ☐ **Yes** ☐ **No**

(if Yes, please specify): _____

Prenatal care received? ☐ **Yes** ☐ **No**

(if Yes, please specify): _____

Type of delivery: ☐ **Vaginal** ☐ **C-Section** ☐ **Forceps/Vacuum**

If C-Section, why? _____

Was the baby breech? ☐ **Yes** ☐ **No**

Any medications or smoking during pregnancy? ☐ **Yes** ☐ **No**

(If Yes, please specify): _____

Problems with labor/delivery? ☐ **Yes** ☐ **No**

(If Yes, please specify): _____

Length of stay in nursery: _____ Any nursery complications? ☐ **Yes** ☐ **No**

(If Yes, please specify): _____

Birth Defects? ☐ **Yes** ☐ **No** *(If Yes, please specify):* _____

Did the child receive Hep B vaccine? ☐ **Yes** ☐ **No**

Did the child pass Hearing Test? ☐ **Yes** ☐ **No**

PATIENT'S CHILD DEVELOPMENT HISTORY:

At what age did the patient sit alone: _____ walk alone: _____ **say words**: _____ **toilet train (daytime): _____**

Any concerns about the patient's development? _____

PATIENT'S NUTRITIONAL HISTORY:

Was the patient breastfed? ☐ **Yes** ☐ **No**

Has the patient had any unusual feeding or dietary problems? ☐ **Yes** ☐ **No**

If yes, please specify: _____

Milk intake: Number of oz. per day: _____ ☐ **Cow milk** ☐ **Non-fat** ☐ **1% Fat** ☐ **2% Fat** ☐ **Whole milk**

☐ **Soy milk** ☐ **Rice milk** ☐ **Almond milk** ☐ **Coconut milk**

What is the water source at home? ☐ **City** ☐ **Well**

Any concerns about the patient's nutritional status? _____

IMMUNIZATION/PREVENTIVE CARE HISTORY:

Please bring the patient's immunization records to your appointment or submit the records electronically via our website.

Has the patient had ☐ **Chickenpox** ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Meningitis** ☐ **Tuberculosis (TB)** or ☐ **None**

Has the patient been seen by a dentist? ☐ **Yes** ☐ **No**

If yes, please list the provider name and date of last visit: _____

Has the patient had an eye exam? ☐ **Yes** ☐ **No**

If yes, please list the provider name and date of last exam: _____

PATIENT'S HABITUAL BEHAVIOR:

How many hours of undisturbed sleep does the patient get per night? _____

Number of naps per week: _____ Duration/Length of each nap taken: _____

Any sleep problems? _____

Hours per day the patient spends: Watching TV: _____ On computer/iPad: _____ Playing video games: _____

Sports/Exercise Type: _____ **Hours per week: _____**

FEMALES ONLY:

Have menstrual cycles started/began? ☐**Yes** ☐**No** *If yes, at what age?* _____ ☐**Regular** ☐**Irregular**

If the patient's menstrual cycles are regular, the cycles start every: _____ *days*

If the patient's menstrual cycles are irregular, the cycles start every: _____ *to* _____ *days*

Date of first day of last menstrual cycle: _____ **Duration of the cycle:** _____ **days**

Number of pregnancies: _____ **Number of deliveries:** _____ **Number of Miscarriages:** ____ **Number of Abortions:** _____

MALES ONLY:

Is the patient circumcised? ☐**Yes** ☐**No**

ENVIRONMENTAL EXPOSURE:

Any concerns about lead exposure? (Ex: Old home, plumbing, peeling paint) ☐**Yes** ☐**No**

Do any household members smoke? ☐**Yes** ☐**No**

SOCIAL HISTORY:

Is the patient currently attending daycare or school? ☐**Yes** ☐**No**

If yes, specify current grade and name of school: _____

If over 4 years old, does the patient have a best friend? ☐**Yes** ☐**No**

Smoking/Tobacco Use: ☐**Current** ☐**Past** ☐**Never**

If current or past, specify: Type: _____ *Amount per day:* _____ *Number of Years:* _____

Has the patient ever used: **Alcohol**: ☐**Yes** ☐**No** **Recreational drugs:** ☐**Yes** ☐**No**

Abused prescription drugs: ☐**Yes** ☐**No**

Is the patient sexually active? ☐**Yes** ☐**No**. *If yes, how many partners has the patient been sexually active with?* _____

Any concerns about substance abuse, sexual activity, school performance, relationships, or any behavior?

_____

_____

FAMILY HEALTH HABITS:

Who does the patient live with? _____

Living Condition: ☐**Home or apartment** ☐**Other:** _____

Are the patient's parents ☐**Married** ☐**Unmarried** ☐**Separated/Divorced.** *If separated/divorced, when?* _____

Mother's occupation: _____ **Employer:** _____ ☐**Full-time** ☐**Part-Time**

Father's occupation: _____ **Employer:** _____ ☐**Full-time** ☐**Part-Time**

Other than yourself, does anyone else take care of the minor patient? _____

SAFETY PRECAUTIONS:

Does the patient use a seatbelt, a booster, or a car seat? ☐ **Yes** ☐ **No**

Does the patient know how to ride a bicycle? ☐ **Yes** ☐ **No** *If Yes, does the patient use/wear helmet?* ☐ **Yes** ☐ **No**

Are there any firearms within the patient's home? ☐ **Yes** ☐ **No**

If yes, what cautionary measures are taken to ensure that the minor child/patient cannot access any firearm(s)?

(Ex: Locked up in safe/vault, etc.) _____

Are there fully functioning smoke detectors located within the patient's home? ☐ **Yes** ☐ **No**

List other medical providers that the patient sees or receives treatment from on a regular basis.

(Ex: Cardiologist, Mental Health Provider, Kidney Specialist, and Dentist.)

_____

_____

PHARMACY: _____

Are there any other concerns that you would like to discuss during the patient's visit today?

_____

_____

Signature: _____ _____ _____ _____

Patient's Legal Guardian *Print Name* *Relationship* *Date*

Provider Signature: _____ Date: _____