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 Well 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: _____ ☐

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: _____