PINNACLE
Family Health Care

Provider: Sasipha "Kate" Pahamark (Family Nurse Practitioner)
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Return 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

1) Has the patient had any ER or Urgent Care visits since their last visit to our office?

☐ Yes ☐ No *If yes, please specify:*

Facility Name	Reason(s) for Visit(s)	Date of Visit	Follow-Up Care?

2) Has the patient been admitted to a hospital or any other facilities since their last visit to our office?

☐ Yes ☐ No *If yes, please specify:*

Facility Name	Reason(s) for Admission	Admission Date	Discharge Date	Follow-Up Care?

3) Has the patient had any medical tests performed since their last visit to our office?

☐ Yes ☐ No *If yes, please specify:*

Test Name	Date	Where?	Follow-Up Care?

4) Has the patient developed any new allergies or had a bad reaction to a medication or food since their last visit to our office? ☐ Yes ☐ No

If Yes, please describe: _____

5) Has the patient been evaluated by a specialist (such as a provider for diabetes, heart, kidney, cancer, eyes, gynecology) since their last visit to our office?

☐ Yes ☐ No *If yes, please specify:*

Provider Name	Reason for Visit(s)	Date of Visit(s)

6) Has the patient received any vaccinations since their last visit to our office? ☐ **Yes** ☐ **No**

If Yes, please specify the vaccinations the patient received and date(s): _____

_____

7) Has the patient started any new medications since their last visit to our office? ☐ **Yes** ☐ **No**

If Yes, please specify: _____

8) 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:** _____