



Welcome to the Pediatric Clinic
Pediatric Clinic Information

Patient name _____ Date of birth _____ School grade _____
Diagnosis _____ Reason for visit _____
Last visit to NIH _____ Reason for last visit _____
Do you have a Bar-Code ID Yes ___ No ___

Recent exposures to infectious diseases, including family members or friends
accompanying patient Yes ___ No ___ Please notify staff ASAP if Yes.

Medication Allergies _____ Reaction _____

Food Allergies _____ Reaction _____

Immunizations up to date Yes ___ No ___

Recent hospitalizations or surgeries _____

Brief medical history _____

Central line or port Yes ___ No ___ Type _____ Location _____

Difficulty or concerns with central line/port _____

Last flush date _____ Last dressing change _____

Labs/blood work drawn in the last 6 weeks Yes ___ No ___

Medications Provide list of current medications if available, if not complete below

Drug Name	Dose	Frequency	Last Time Taken	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

For NIH prescribed drugs, do you need a refill this visit Yes ___ No ___

Are you experiencing any pain Yes ___ No ___ Location _____

Current health complaints _____

Communicable Disease History

History of Chickenpox Yes ___ No ___

History of Measles Yes ___ No ___

History of Tuberculosis Yes ___ No ___

History of Drug Resistant Infections (i.e. MRSA, VRE) Yes ___ No ___

Falls in the last 3 months Yes ___ No ___ Injuries _____

Home care services _____

Rehab therapy or special education _____

Questions or concerns _____

Parent/Guardian Name _____ Contact /Cell Phone # _____

Location of lodging _____ Secondary Contact # _____