Town Clinic of Crested Butte, PLLC

P.O. Box 1546
Crested Butte, CO 81224

214 6th Street, Suite 1
(970) 349-6749

Eric Thorson, M.D.

New Pediatric Patient Health History

Last Name:_______________________ First Name:______________ DOB: __ __/__ __/__ __ __ __
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Would you like to have Dr. Thorson as your Primary Care Provider (PCP)? Y N

Past Medical History: (please mark any that apply and explain)

- ☐ Abdominal complaints
- ☐ ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Depression
- ☐ Diabetes
- ☐ Frequent ear infection
- ☐ Frequent strep throat
- ☐ Heart condition/murmur
- ☐ Headaches
- ☐ Kidney, urine infections
- ☐ Thyroid
- ☐ Other (*explain below*)

Explanation:____

____

Past Surgeries or Hospitalization:

Surgery/ Hospitalization	Date
1.	
2.	
3.	
4.	
5.	

Medications: (please include over the counter, herbal supplements, and birth control)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		

Allergies: ☐ Drug/medication allergies (*please explain below*):

Explanation:____

____

____

- ☐ No known drug allergies
- ☐ Animals
- ☐ Food
- ☐ Environmental
- ☐ No allergies at all

Is the patient current with childhood immunizations: Yes No

Turn over for page 2.

Review of Systems: (please check the system(s) and circle the condition(s) that applies today)

- ☐ **Breasts**: Skin changes, mass, pain, discharge
- ☐ **Ears**: Hearing loss, ringing, pain, discharge
- ☐ **Eye**: Visual change, blurred vision, glasses
- ☐ **Endocrine**: Heat/cold intolerance, excessive sweating, frequent urination, excessive thirst, thyroid problems, diabetes
- ☐ **GI**: Stomach-ache, nausea, vomiting, diarrhea, constipation, blood in stool, hemorrhoids, hepatitis
- ☐ **General**: Fever, chills, weight change, weakness
- ☐ **Genital**: Discharge, STDs, sores, abnormal periods, pain with intercourse, impotence
- ☐ **Head**: Trauma, headache
- ☐ **Heart**: Chest pain, high blood pressure, murmurs, palpitations, swelling, trouble lying flat
- ☐ **Hematologic**: Anemia, easy bruising, bleeding, transfusions
- ☐ **Lungs**: Short of breath, wheeze, cough, asthma, pneumonia, COPD
- ☐ **Mouth / Throat**: Sore, hoarseness, cavities
- ☐ **Muscles / Bones**: Weakness, pain, joint stiffness, arthritis, gout
- ☐ **Neuro**: Dizziness, loss of sensation, weakness, tremor, tingling, fainting
- ☐ **Nose**: Runny, blood, sneezing, itchy
- ☐ **Psychiatric**: Depression, anxiety, tension, memory difficulty
- ☐ **Skin**: Rash, hair change, nail change, moles
- ☐ **Urine**: Painful, frequency, discharge, blood
- ☐ **Vessels**: Leg swelling, painful walking, varicose veins, history of blood clots
- ☐ **Other**: (Please explain):____________________
____

Explanation:____
____

Family History: (e.g., cancer, diabetes, heart disease, high blood pressure, etc.).

Mother:____
Father:____
Siblings:____

Social History:

Race (please list):________________________________

Ethnicity (circle): Hispanic/Latino or Not Hispanic/Not Latino

Preferred Language (please list):______________________

Does the child attend school: Y N If Yes, which grade________

School performance is: Excellent Good Fair Poor NA

Does the child attend daycare: Y N

Who lives with the child (*please list*):______________________________________

Is there smoke exposure in the home: Y N

Are there pets in the home: Y N If Yes, what types______________________

When was the last dental visit: ____________ months

The child's diet is: Excellent Good Fair Poor

Other important factors to this patient's health history:

____

Today's Date: ____________________

Staff Use Only						
Temp	**BP**	**Pulse**	**Sat.**	**RR**	**Ht.**	**Wt.**