Patient Update Information

David J. Siegler, M.D.

Patient Sticker Today's Date: _____

Patient Name _____ Male / Female Nickname _____

Date of Visit: _____ **Previous Visit:** _____

Reason for Visit _____ ☐ new problem ☐ Old problem

Pediatrician or Family Physician _____ ☐ Same ☐ Different

Person filling out form: _____Relationship to patient: _____

Patient's Medical History since last visit:

Has child had any:	**No**	**Yes**	**Details**
Hospitalizations:	☐	☐	_____
Surgeries:	☐	☐	_____
Serious Illnesses:	☐	☐	_____
Head Injuries:	☐	☐	mo/yr _____ Passed out? _____ Confused? _____Seen by Dr?_____
Medication Allergies:	☐	☐	Med: _____Reaction: _____
Food/other allergies:	☐	☐	Item: _____Reaction: _____

Present Medications ☐None

Name	Dose	Reason for Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medications stopped since last visit:

Name	Highest Dose	Reason Used	Reason Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Family History: Any new developments? ☐ No ☐ Yes: if yes, please provide details:

(circle only the disorders in the family & write person's relation to patient; ie. Mom, maternal uncle)

Migraines	_____	Seizures	_____	Clotting	_____
Headaches	_____	Epilepsy	_____	Aneurysms	_____
Tics	_____	Passing out	_____	Heart Disease	_____
Cerebral Palsy	_____	Muscles	_____	Stroke under 50	_____

Social History: Patient lives with? _____

Parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated

Custody (if applies): Mom has _____ % Dad has _____ % Documents available: ☐ yes ☐ no

Patient is a ☐ Natural Child ☐ Adopted ☐ Foster Child (in DHS custody) ☐ Other: _____

School: (circle): too young pre-school grade level _____

School_____ home-schooled home-bound other: _____

School Performance: A B C D F _____

Any high risk behaviors? (ie. alcohol/drug use, sexual activity) ☐ no ☐ yes _____

Any social stressors or concerns? _____

Any Developmental Changes or Concerns? ☐ **no** ☐ **yes** _____

_____

Any recent tests? ☐ **no** ☐ **yes** _____

☐ **EEG** (where?) _____

☐ **Head CT/ MRI** (where?) _____

☐ **Labs** (where?) _____

Description of problem(s): ☐ **Already filled out form** ☐ **Did not fill out form: see below:**

_____

_____

_____

_____

Is patient's problem related to an injury or accident? ☐ No ☐ Yes: _____

If yes, do you plan a lawsuit or is a lawyer involved? ☐ No ☐ Yes: Attorney:_____

Attorney Tel# _____

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Circle any of the following the patient is presently experiencing:

General:

Fatigue Sleeps a lot Sleeps poorly
Recent Fevers Weight Loss Weight Gain

Ears-Nose-Mouth-Throat

Hearing problems: loss ringing
Hoarse Voice Onset? _____
Chokes on food/drink Onset? _____

Respiratory

Shortness of breath Onset? _____
Wheezing Onset? _____
Chronic Cough Onset? _____

Genito-Urinary

Dark colored urine (like cola)
Wets self (toilet trained) at night during day
Soils self (toilet trained) at night during day
Menstrual periods Onset? _____

Skin

Recurrent Rash of face / joints
Coffee spots How many? _____
White spots How many? _____

Hematologic

Bruises easily
Bleeding takes long to stop

Psych-Behav

Homocidal or Suicidal thoughts or attempts
Hallucinations Depressed
Perfectionistic Overly clean
Obsessive-Compulsive Lots of fears
Has many rituals
Anger problems Hurts others
Poor attention Is easily distracted
Hyperactive Acts without thinking
Is not very social Has no friends
Has poor eye contact Has been arrested
Dislikes seams / tags / tight clothes

Eyes

Vision: poor blind wears contacts / glasses
Eye pain Onset? _____
Visual blackouts Onset? _____
Double vision Onset? _____

Cardiovascular

Chest pains Onset? _____
Palpitations Onset? _____
Irregular heart beat Onset? _____

Gastrointestinal

gags often Onset? _____
often nauseated Onset? _____
spits-up/vomits often Onset? _____
frequent diarrhea Onset? _____
chronic Constipation Onset? _____

Musculo-Skeletal

muscle pains muscle cramps
joint pain / swelling Onset? _____
reported curved spine

Endocrine

Excessive thirst Frequent urination
Heat intolerance Cold intolerance

Neuro (other than for reason for being here)

Headaches
Seizures
Staring spells
Tics
Involuntary movements
Learning Disability
Mental Retardation