OhioHealth

OhioHealth Women's Health Primary CarePhysicians
Patient Chart Summary Intake Form for Children (Pediatric)

Form Directions: Please provide the patient information requested below. Once you have completed the entire form, please return it to the OhioHealth Women's Health Primary Care Physicians office in person, by mail at 1020 Cricket Lane, Mansfield, Ohio 44906, or fax the form to (419) 526-8859. All forms must be submitted prior to your initial appointment.

SECTION 1: PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Maiden Name: _____ Nickname: _____

Check ✓ all that apply to the patient: ❑ homeless ❑ does not have address ❑ does not have phone ❑ lives in nursing facility

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Residential Address: _____ ❑ Same as Mailing Address

City: _____ State: _____ Zip Code: _____ County: _____

Email: _____

Primary Home Phone: (_____) _____ Cell Phone: (_____) _____

Social Security Number: _____ - _____ - _____ Date of Birth (MM/DD/YYYY): ____/____/____

Gender: ❑ Male ❑ Female Language: _____ Marital Status: _____

Religious Affiliation: _____ Race: _____ Ethnicity: ❑ Hispanic ❑ Not Hispanic

EMERGENCY CONTACT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Relationship to Patient: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: _____

PATIENT EMPLOYMENT:

Employer Name/Address: _____

Status: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ _____ Work Phone Number: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Retired Date (if applicable): _____

PATIENT MEDICAL INFORMATION

Primary Care Provider Name (Family Physician): _____ ❑ None

What are the primary reasons for the patient's visit to our office? _____

_____

Are you being referred to this office by another physician? Name: _____

ADVANCED DIRECTIVES

Check (✓) any that apply. Please bring a copy of any advanced directive forms with you to your next appointment.

❑ None ❑ DNR (Do Not Resuscitate) ❑ Living Will ❑ Do Not Place on Life Support
❑ Healthcare Proxy ❑ Durable POA (Power of Attorney)

GUARDIAN OR RESPONSIBLE PERSON (OF A MINOR OR OTHER PERSON):

Relationship to Patient: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: _____

Last Name: _____ First Name: _____ MI: _____

Employer Name/Address: _____

Gender: ❑ Male ❑ Female Social Security Number: _____ - ____ - _____ Date of Birth: ____/____/_____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

SECTION 2: PATIENT MEDICATIONS*

❑ Check (✓) this box if the patient takes no medications.

	Medication Name (brand or generic name)	**Medication Strength/Dosage** (example: 40 mg or 5 oz)	**Prescribed Medication Directions** (example: one pill daily by mouth at bedtime)
1			
2			
3			
4			
5			
6			
7			
8			

**If additional space is needed for Medications, please attach a list to this form.*

SECTION 3: PATIENT ALLERGIES*

❑ Check (✓) this box if there are no known allergies.

	Specific Allergy Name or Type (medications and environmental)	**Bodily Reactions to the Allergy** (Itching, breathing, stomach issues, etc.)	**Allergy Severity** (mild, moderate, severe)	**Onset Date**
1				
2				
3				
4				
5				
6				
7				
8				

**If additional space is needed for Allergies, please attach a list to this form.*

SECTION 4: PATIENT PAST MEDICAL AND SURGICAL HISTORY*

Have you ever had any problems or surgery in any of the body areas below? Check (✓) Yes or No. If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eye	❑ Yes ❑ No	Ear	❑ Yes ❑ No	Nose/Throat	❑ Yes ❑ No
Lung	❑ Yes ❑ No	Bowel/Bladder	❑ Yes ❑ No	Liver	❑ Yes ❑ No
Kidney	❑ Yes ❑ No	Muscle/Bone	❑ Yes ❑ No	Skin	❑ Yes ❑ No
Neurological	❑ Yes ❑ No	Endocrine	❑ Yes ❑ No	Stomach	❑ Yes ❑ No
Heart	❑ Yes ❑ No	Bleeding/Clotting	❑ Yes ❑ No	Other – Not Listed	❑ Yes ❑ No

❑ Check (✓) this box if the patient has no relevant past medical and surgical history.

	Disease or Problem	**Date Diagnosed**	**Procedures, Surgeries, Tests, or Management of the Disease** (include outcome and dates)	**Additional Comments**
1				
2				
3				
4				
5				
6				
7				
8				

**If additional space is needed for Past Medical History, please attach a list to this form.*

SECTION 5: PATIENT FAMILY MEDICAL HISTORY*

Have any of your family members (father, mother, sibling, children, or grandparents) ever had any problems or surgery in any of the body areas below? If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eye	❑ Yes ❑ No	Ear	❑ Yes ❑ No	Nose/Throat	❑ Yes ❑ No
Lung	❑ Yes ❑ No	Bowel/Bladder	❑ Yes ❑ No	Liver	❑ Yes ❑ No
Kidney	❑ Yes ❑ No	Muscle/Bone	❑ Yes ❑ No	Skin	❑ Yes ❑ No
Neurological	❑ Yes ❑ No	Endocrine	❑ Yes ❑ No	Stomach	❑ Yes ❑ No
Heart	❑ Yes ❑ No	Bleeding/Clotting	❑ Yes ❑ No	Other – Not Listed	❑ Yes ❑ No

❑ Check (✓) this box if the patient has no relevant family medical history.

	Diagnosis or Problem	**Family Member - Relation**	**Age of Onset**	**Age of Death**	**Additional Comments**
1					
2					
3					
4					
5					
6					
7					
8					

**If additional space is needed for Family History, please attach a list to this form.*

SECTION 6: PATIENT SOCIAL HISTORY

Primary Language: _____ Language Spoken at Home: _____

Primary Caregiver

First and Last Name of Primary Caregiver: _____

Primary Caregiver: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: _____

How many days during a week does the patient spend with the primary caregiver? (circle one) 1 2 3 4 5 6 7

Secondary Caregiver

First and Last Name of Secondary Caregiver: _____

Secondary Caregiver: ❑Mother ❑Father ❑Step-Mother ❑ Step-Father ❑Foster Parent ❑Grandparent ❑Other: _____

How many days during a week does the patient spend with the secondary caregiver? (circle one) 1 2 3 4 5 6 7

Smoke Exposure (check ✓ one): ❑ Smokers at home ❑ Outside smoke only

Hand Dominance (check ✓ one): ❑ Right ❑ Left ❑ Ambidextrous (both hands)

Patient Childcare

Does the patient attend daycare? ❑ Yes ❑ No Days per week: _____ Daycare Name: _____

Patient Information

Parents' Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Legally Separated ❑ Polygamous ❑ Unknown

Number of Siblings: _____ Birth Order: ❑ First ❑ Second ❑ Third ❑ Fourth ❑ Fifth ❑Other: _____

Does the patient use bike/skate helmet when biking or skating? ❑ Yes ❑ No

Car restraints (check✓): ❑ Car seat: face rear ❑ Car seat: face front ❑ Booster ❑ Seat belt ❑ None

Patient Education

School Name: _____ Grade Level: _____

Check (✓) all that apply to the patient: ❑ Learning Disability ❑ Special Needs ❑ Gifted Program
❑ Likes school ❑ Truancy ❑ College Prep ❑ H.S. Graduate

How is the patient performing in school? (Check ✓ one): ❑ Below grade level ❑ At grade level ❑ Above grade level

Additional Information

Check (✓) all that apply to the patient: ❑ Takes naps ❑ Sleeps with parents ❑ Sleeps through the night
❑ Sleeps minimum 8.5 hours nightly ❑ Nightmares/sleep problems

How many hours per day will the patient: _____ Exercise/play sports _____ Watch TV _____ Use the Internet

Does the patient use caffeine? (check ✓ one) ❑ Yes ❑ No

Caffeine Type(s): ❑ Coffee ❑ Chocolate ❑ Energy Drink ❑ Tea ❑ Other Amount of caffeine per day: _____

SECTION 7: PATIENT PREFERRED PHARMACY

(#1) Pharmacy Name: _____ Location/City: _____

(#2) Pharmacy Name: _____ Location/City: _____

FOR OFFICE USE ONLY **Date Received:** _____

Chart Abstracted by: _____ Date Abstracted: _____