KEARNEY REGIONAL Medical Center | PLATTE VALLEY MEDICAL CLINIC

Date__________________

Pediatric 0-12 years

Name____DOB___/___/___

Primary Care Physician____________________________ **Referring Physician______________________**

List all medication prescription and nonprescription

Primary Pharmacy_______________________________ **No Medications________**

Medications **Medication Dose___**

1. ________________________________ ___________________________________
2. ________________________________ ___________________________________
3. ________________________________ ___________________________________
4. ________________________________ ___________________________________
5. ________________________________ ___________________________________
6. ________________________________ ___________________________________
7. ________________________________ ___________________________________

Medication Allergies

Medication **Reaction** (hives, nausea, vomiting, etc.)

- ____ __________________________________
- ____ __________________________________
- ____ __________________________________
- ____ __________________________________

Past Medical History

(Closest date of diagnosis if known)

- Abdominal pain __/__/___
- Acne __/__/___
- ADD __/__/___
- ADHD __/__/___
- Allergies __/__/___
- Anemia __/__/___
- Asthma __/__/___
- Birth trauma __/__/___
- Bleeding disorder__/__/__/___
- Bronchitis __/__/___
- Chickenpox __/__/___
- Concussion __/__/___
- Congenital Heart Disease __/__/___

Diabetes __/__/___
Eczema __/__/___
Fracture __/__/___
(site)___________
GERD __/__/___
Head injury __/__/__
Headache/ Migraines __/__/___
Menstrual problems __/__/___
Otitis media __/__/___
Pneumonia __/__/___
Prematurity __/__/___

Pyelonephritis __/__/___
Seizure disorder __/__/___
(type)________________
Urinary Infections__/__/___
Other ___________________
Other____________________
Other____________________
Disorders: examples (bipolar, behavior, cognitive)
Other___________________
Other __________________
Other___________________
Other __________________

Pediatric Surgical History

- Adenoidectomy ___/___/___
- Appendectomy ___/___/___
- Blood transfusion ___/___/___
- Dental surgery ___/___/___
- Hernia repair ___/___/___
  (Inguinal)
  (Umbilical)

Arthroscopy Knee R)__ L)__ ___/___/___
Open Reduction Internal Fixation (ORIF)
Which limb R)__L)__ ___/___/___
Other________________________________
Other________________________________
Other________________________________

Immunizations 0-18 years

Hepatitis B ___/___/___ Polio___/___/___(IPV) HIB ___/___/___ Dtap, ___/___/___

Hepatitis A ___/___/___ Influenza___/___/___ MMR ___/___/___ Varicella ___/___/___

Rotovirus ___/___/___ HPV ___/___/___

Pneumococcal (Prevnar) ___/___/___ Meningococcal ___/___/___

New patients please have consent form signed for release of Medical History from previous Medical Clinics.

Please bring the forms with you to your appointment. Thank you.