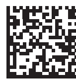
BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115



PATIENT IDENTIFICATION AREA

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Pediatric Outpatient Self Assessment Form

Date of visit: __________________ Age:______________

Patient Name: ____ Date of Birth: _____ / _____ / _____

Mother's Name: ______________________________________ Father's Name: ______________________________________

Mother's Occupation: _________________________________ Father's Occupation: __________________________________

Pediatrician Name and Address:____

Reason for today's visit: ____

Current Medications: ____ (Use reverse for more space)

List all current non-prescribed medications (including homeopathic):

1. ___________________________________ 2. ___________________________________ 3. ___________________________________

Allergies to Medication: ❒ No ❒ Yes If yes, please list: ____

Previous operations and hospitalizations:

	Date	Illness/Surgery	Hospital
1.	_______________	____	_________________________
2.	_______________	____	_________________________ (Use reverse for more space)

Any problems with pregnancy or delivery? ❒ No ❒ Yes If yes, please list: ____

Please check if child has had any of the following:

❒ Hearing loss or ringing
❒ Frequent ear infection
❒ Dizziness
❒ Frequent exposure to loud noises
❒ Allergies (environmental)
❒ Recurrent sinus infections
❒ More than 3 sore throats/yr
❒ Snoring or sleep apnea
❒ Hoarseness or laryngitis
❒ Persistent cough
❒ Shortness of breath

Has there been testing for any of the above problems? ❒ No ❒ Yes If yes, what test(s) and when/where were they done?

____

____

Please check if child has had any of the following:

❒ Asthma
❒ Bronchitis
❒ Acid reflux
❒ Tuberculosis
❒ Anemia
❒ Bleeding problem
❒ High blood pressure
❒ Heart murmur
❒ Rheumatic fever
❒ Congenital heart disease
❒ Hepatitis
❒ Diabetes
❒ Cancer
❒ Behavioral disorders
❒ Development disorders
❒ Head injury (date________________)
❒ Seizure/fainting spells
❒ Chronic headache/migraines
❒ Depression/Anxiety
❒ History of radiation therapy or exposure

Other, please specify ____

Is there a family history of hearing loss, allergies or bleeding problems? ❒ No ❒ Yes If yes, please CIRCLE appropriate one.

Did you receive a copy of the *"We Care About Your Safety Brochure"*? ❒ No ❒ Yes

Do you understand how to prevent the spread of germs? ❒ No ❒ Yes