_**Chart Number: Name:**_____ _____ _____ chart: date: time: **DOB:**

primary physician:
age:
last e-mail, call or visit:

Brian H. Washburn, M.D., FAAP
37 Brendan Way
Greenville, SC 29615
Telephone (864) 458-7792
e-mail: mail@greenville-pediatrics.com
http://www.greenville-pediatrics_pa.mymedfusion.com

Please help us by answering the following, and return to our receptionist:

What is 's concern that brings you for this visit?

_____

_____

History of Present Illness:

Associated signs and symptoms:

(yes)

- ☐ none
- ☐ cough morning
- ☐ congestion
- ☐ fever low grade 100.5-101.5
- ☐ rash
- ☐ irritability
- ☐ sleep disturbance (hard to go down)
- ☐ sleep disturbance (going down and awakening with difficulty going back to sleep)
- ☐ vomiting (only after coughing) yes
- ☐ diarrhea
- ☐ appetite change increased
- ☐ malaise
- ☐ headache
- ☐ sore throat
- ☐ stomach ache
- ☐ muscle aches
- ☐ other _____

Duration of illness:

_____ hours _____ days ago _____ hours ago _____ months ago

(yes)

- ☐ an extended duration
- ☐ an unknown duration
- ☐ constant
- ☐ intermittent
- ☐ other _____

Location of problem:

_____

Modifying Factors: (select one if appropriate)

Rest improves the condition.
Medication imporves the condition.
Which medications(s) _____

(yes)
- ☐ no modifying factors
- ☐ other _____

Quality of illness or problem:

(yes)
- ☐ worsening
- ☐ unchanging
- ☐ does interfere with normal activity
- ☐ other _____

Severity:

(yes)
- ☐ improving
- ☐ moderate
- ☐ resolved
- ☐ severe
- ☐ worse at night
- ☐ other _____

Timing:

_____ days ago _____ weeks ago

(yes)
- ☐ constant
- ☐ during evening
- ☐ during the fall
- ☐ during the spring
- ☐ during the summer
- ☐ during the winter
- ☐ while eating
- ☐ improved after eating
- ☐ with exercise/exertion
- ☐ diurnal
- ☐ other _____

Any other family members ill: (yes) ☐ _____

Any peers ill: (yes) ☐ _____

Medications: (no) ☐
(yes) ☐_____

have you obtained information on the internet ? (yes) ☐
if yes
what:_____

Which Pharmacy would you like your prescription sent to? _____

Is there anything else concerning _____, that you would like to discuss in your visit today?

Allergic or Immunologic Symptoms: (yes) ☐
(yes)
- ☐ Coughing
- ☐ Eyes watering
- ☐ Sneezing
- ☐ Other:_____

Bleeding Problems/ Lymphatic : (yes) ☐
(yes)
- ☐ Frequent nose bleeds
- ☐ Pale, pallor
- ☐ Swollen lymph nodes
- ☐ Other:_____

Breathing Difficulties, Respiratory Symptoms: (yes) ☐
(yes)
- ☐ Breathing difficulties, Respiratory symptoms
- ☐ Cold-like symptoms
- ☐ Snoring
- ☐ Recent asthma attack
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing
- ☐ Other:_____

Cardiovascular Problems or Chest Symptoms: (yes) ☐
(yes)
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ chest pain
- ☐ Other:_____

Constitutional Symptoms such as Fever, Headache, Nausea, Dizziness: (yes) ☐
(yes)
- ☐ appetite decrease
- ☐ Fever
- ☐ Headache
- ☐ Nausea
- ☐ Dizziness
- ☐ Malaise (overall general discomfort, feeling of "being out of sorts")
- ☐ Weight loss, unintentional
- ☐ sleep problems
- ☐ irritability
- ☐ Other:_____

Endocrine-Related Symptoms: (yes) ☐

(yes)

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Weight change
- ☐ Other:_____

Eye or Vision Problems: (yes) ☐

(yes)

- ☐ Blurred vision
- ☐ Photosensitivity (bright light is unusually painful)
- ☐ Other:_____

GI symptoms such as Stomach or Abdominal Problems: (yes) ☐

(yes)

- ☐ Abdominal cramps
- ☐ Bowel habit change
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excess gas
- ☐ Vomiting
- ☐ Other:_____

GU Symptoms (Genitourinary): (yes) ☐

(yes)

- ☐ Hematuria (blood in urine)
- ☐ Burning w/ urination
- ☐ Urinary frequency
- ☐ Other:_____

Joint or Musculoskeletal Symptoms: (yes) ☐

(yes)

- ☐ Back pain
- ☐ Difficulty/limited exercise
- ☐ Joint or musculoskeletal symptoms
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Neck pain
- ☐ Weakness
- ☐ Other:_____

Neurological Symptoms or Problems: (yes) ☐

(yes)

- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness or tingling
- ☐ Recent seizure
- ☐ Syncope (passing out, loss of consciousness)
- ☐ Other:_____

Psychiatric or Emotional Difficulties: (yes) ☐

(yes)

- ☐ Anxious feelings
- ☐ Depression
- ☐ Irritability
- ☐ Poor anger control
- ☐ Poor sleep pattern
- ☐ Aggression
- ☐ Attention problems
- ☐ Learning problems
- ☐ Other:_____

Skin-Related Symptoms: (yes) ☐

(yes)

- ☐ Contact Dermatitis
- ☐ Dermatitis
- ☐ Eczema
- ☐ Moles
- ☐ Rash
- ☐ Other:_____

Symptoms Involving Ears, Nose, Mouth, or Throat: (yes) ☐

(yes)

- ☐ Epistaxis (Nose Bleed)
- ☐ Ear drainage
- ☐ Runny nose
- ☐ Sore throat
- ☐ Ulcers in mouth
- ☐ Ear pain
- ☐ Stuffy nose
- ☐ Other:_____

Has anything changed since your last visit to the doctor? _____

_____.