Name:

Patient DOB: ____/____/_____

Room:

Recent ER, Urgent Care, Specialty Care Visits, Impatient Stay? ☐ No ☐ Yes, Date:_____ Location:_____			
Allergies (please list onset and reaction):			
Medications, Supplements /last time taken:			
Annual Questions			
Preferred Name (child):			
Preferred Spoken Language: English ☐ Other:		Preferred Written Language: English ☐ Other:	
Preferred mode of communication (circle one): ☐ Verbal ☐ Sign Language ☐ Written ☐ Assistive Technology ☐ Communication Device			
Preferred method of learning (select all that apply): ☐ None ☐ Demonstration ☐ Printed Materials ☐ Verbal Explanation ☐ Video/Educational TV ☐ Internet Other:_____			
Preferred method of communication (circle one): ☐ No preference ☐ Printed Letter ☐ Phone Call ☐ Patient Portal ☐ Email:_____			
Cultural or Religious beliefs that may affect patient care? ☐ No ☐ Yes (specify):			
Do you (parent) have any learning barriers? (Ex. Language barrier, hearing/vision deficit) ☐ No ☐ Yes (specify):			
Do you need help reading instructions from your Doctor or Pharmacy? (please circle one choice): ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always			
Previous medical / surgical history:			
Family medical history:			
Social History			
Any upcoming deployment/PCS	☐ No	☐ Yes, Date:_____ Location:_____	
Do you feel safe at home?	☐ No	☐ Yes	
Exposure to secondhand smoke?	☐ No	☐ Yes, packs/day: _____ total # yrs: _____	
Do you live in military housing?	☐ No	☐ Yes	
Pets?	☐ No	☐ Yes, # and species of pets:	
Siblings?	☐ No	☐ Yes, # of siblings:	
School Name and Grade:	Daycare ☐ No ☐ Yes		
School Type (circle which applies):	Public, Private, Homeschooled		
Nutrition			
Breastfeeding (circle) ☐ <5 min. ☐ 5-10 min. ☐ 10-15 min. ☐ 15-20 min.		Frequency: Every _____ hours	
Formula Brand:	_____ oz or ml	Frequency: Every _____ hours	
Meals/day:		Snacks/day:	
Milk type:		Caffeinated drinks? ☐ Y ☐ N	
Elimination			
Stools/day:	Wet diapers/day:	Potty Trained? ☐ Y ☐ N	
Sleep hrs/night:_____			
☐ Crib / Bassinet	☐ Pack & Play	☐ Bunk Bed	
☐ Co-sleep	☐ Bed / Own room	Shares room with:	
Exercise (two years and older):	Exercise hrs/day:		
	Screen time hrs/day:		
EFMP Status			
Is the patient enrolled in EFMP?	☐ No	☐ Yes, date initiated: _____	

Please explain any concerns below: