Pediatric Infectious Diseases
Health History Return

PROVIDENCE Children's Health

Appointment date: _____ Patient name: _____

Preferred name: _____ Date of birth: _____ Gender at birth: □ Male □ Female

Gender identity: □ Male □ Female □ Other: _____ Preferred language: _____

What brings you in today? _____

Please check the symptoms you have on a regular basis or right now.		**□ NONE**
□ Poor appetite	□ Weight loss or lack of weight gain	□ Cough
□ Nausea	□ Long lasting or unexplained fevers	□ Wheezing
□ Vomiting	□ Low energy or fatigue	□ Hoarse voice
□ Sore throat	□ Headaches	□ Chest pain
□ Nasal congestion	□ Lightheadedness	□ Irregular heart beat
□ Changes in growth	□ Seizures	□ High blood pressure
□ Abdominal (belly) pain	□ Chills or night sweats	□ Wetting or urine accidents
□ Increased thirst or urination	□ Red or painful eyes	□ Painful urination
□ Diarrhea	□ Frequent mouth sores	□ Back pain
□ Dental problems	□ Achy joints	□ Coordination problems
□ Constipation	□ Red or swollen joints	□ Bleeding or excessive bruising
□ Blood in stool	□ Hair loss	□ Irregular menstrual periods
□ Sleep problems	□ Rash	□ Anxiety or stress
□ Changes in vision	□ Enlarged lymph nodes	□ Depression or sad mood
□ Changes in hearing	□ Heat or cold intolerance	□ Dental problems
□ Other _____		

Current fever pattern □ does not apply

Frequency: _____ times per day OR every _____ days

Other symptoms with fever: □ rash □ conjunctivitis □ joint pain or swelling □ abdominal (belly) pain □ other

Current Medications including prescriptions, supplements, vitamins, herbs **□ NONE**

Medication	Amount you take	How many times per day?
_____	_____	_____
_____	_____	_____

Any updates or new concerns since I last saw you?

Do need a medication(s) refill?

Name of medication(s) _____

Name and location of your pharmacy: _____

Phone number to call with your lab results: _____