Cohen Children's Northwell Health | Concorde PEDIATRICS

General Pediatrics

Help Us Coordinate Your Care

Date: _____ Name: _____ DOB: _____

Reason For Your Visit: _____

Preferred Pharmacy: _____ City/State_____ Phone ( ) _____

If you do not have a preferred pharmacy, please inform us and we can locate one for you.

1) Since your last visit to our office, was your child seen in the ER/Urgicenter or admitted to the hospital?

❒ Y ❒ N

If yes, please write where and when: _____

2) Since your last visit to our office, has your child seen any other doctors?

❒ Y ❒ N

If yes, who did you see and when: _____

3) Since your last visit to our office, has your child had any medical tests? (Blood tests, X-rays, MRI, CT-scan)

❒ Y ❒ N

If yes, please explain type, where and when the tests were done: _____

_____

4) Since your last visit to our office, has your child developed any new allergies or had a bad reaction to a medication, substance or food?

❒ Y ❒ N

If yes, describe: _____

5) Since your last visit to our office, has your child started any new prescribed or over the counter medications? Were there any problems with these medications? (i.e. cost of medications, side effects, etc)

❒ Y ❒ N

If yes, list: _____

6) What is the child's living situation if not with both biological parents?

❒ Lives with adoptive parents ❒ Joint Custody ❒Single Custody ❒ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

7) Has anything changed with the health of your family members (parents, grandparents, siblings) since your last visit?

❒ Y ❒ N

If yes, please list: _____

8) Does anyone in your household smoke (parents, grandparents, siblings, babysitters/caregivers)?

❒ Y ❒ N

If yes, please list: _____

9) Which of the following topics regarding you or your child's health would you like to discuss today?

Patient Issues: ❒Breathing Issues ❒Allergies ❒Weight management ❒Physical activity ❒Nutrition ❒Dental ❒Anxiety/Depression ❒Development

Parental Issues: ❒Breastfeeding ❒Parenting ❒Smoking cessation

❒Other_____

What result(s) would you like to achieve:

Blah blah blah

_____

_____

Barriers that may prevent you or your child from reaching goal: ❒None ❒Housing ❒Behavioral ❒Lack of Understanding ❒Access to Medications ❒Transportation ❒Cultural ❒Financial

❒Other_____