New and Returning Patients

Today's Date: _____

ARKANSAS PEDIATRIC CLINIC

Hornet Health Clinic
412 Woodland Dr
Bryant, AR 72022
501-653-5040

TODAY'S VISIT – Please fill out for each visit

Patient Name: _____ DOB: _____/_____/_____ Male / Female Age:_____

Name of person completing form: _____ Relationship to patient: _____

School / Daycare: _____ Grade: _____ ☐ None

Reason for office visit today: Well child Sick Physical Other: _____

What brought you to the doctor today? (Please circle all that apply)

Fussiness or Irritability	Fever	Poor Appetite	Poor Sleep
Hearing Concerns	Vision Concerns	Eye Drainage	Ear Complaints
Runny Nose	Nasal Congestion	Sore Throat	Chest Pain
Paleness	Tires Easily	Fast/Irregular Heart Rate	Wheezing
Vomiting	Cough	Exposure to Tobacco Smoke	Abdominal Pain
Decreased Urination	Constipation	Diarrhea	Painful Urination
Weakness	Blood in Urine	Frequent Joint Swelling	Leg/Arm/Back Pain
Rash	Difficulty Walking	Acne	Warts/Skin Lesions
Dizziness	Itching	Headache (s)	Seizures
Lymph Node Swelling	Fainting	Bleeds Easily	School Difficulties
Frequent Colds	Excessive Bruising	History of Serious Infection	Speech Concerns
Developmental Delay	Allergies	Behavior/Emotional Problems	Sleep Disturbances
Chest Congestion			

Other: _____

Length of Symptoms: _____

Allergies: _____

Established Patients Only:

Current Medications, Vitamins or Dietary Supplements: _____

_____

To be filled out by your nurse:

Vital Signs Weight: _____lbs ____ oz Height: _____ in. Temp: _____ Pulse Ox% _____

Blood Pressure: _____ / _____ HC _____ in. Pulse: _____ Resp Rate: _____

Immunization risks and benefits discussed: YES NO

Vaccine information given / Consent for Immunizations

X_____

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Has your child seen any other physicians or providers since last visit?

Eye Doctor	_____ (Name)	Last Visit	_____
Allergist/Asthma	_____ _____ (Name)	Last Visit	_____
Gastroenterology	_____ (Name)	Last Visit	_____
ENT	_____ (Name)	Last Visit	_____
OB/GYN	_____ (Name)	Last Visit	_____
Cardiology	_____ (Name)	Last Visit	_____
Mental Health Services	_____ (Name)	Last Visit	_____
Therapies Received (OT,DT,PT,ST)	_____ (Name)	Last Visit	_____
Other	_____ (Name)	Last Visit	_____

Any surgeries or hospitalizations since your last visit?

_____ Date of Occurrence: _____

_____ Date of Occurrence: _____

Any injuries since your last visit?

_____ Date of Occurrence: _____

_____ Date of Occurrence: _____

_____ Date of Occurrence: _____

Has your child been diagnosed with any new medical conditions since your last visit?

_____ Date of Diagnosis: _____