LWMH Peds School/Sports Physical Rodeo

Patient's Full Name: _____ DOB: ____/_____/_____ Phone Number: _____

Preferred Spoken/Written Language (circle): *English / Spanish / Other*_____

Preferred Mode of Communication (circle one): *Verbal / Sign Language / Written / Assistive Technology*

Preferred Method of Learning (circle all that apply): *Demonstration / Printed Materials / Verbal Explanation / Video or Educational TV / Internet*

Preferred Method of Communication (circle one): *Phone call / Printed Letter / Patient Portal / Secure Email*

Are there any cultural or religious beliefs that may affect your child's healthcare (circle)? *No / Yes*_____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from you doctor or pharmacy (circle)? *Never / Rarely / Sometimes / Often / Always*

Is your child in pain today (circle)? *0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)*

Does your child have any of the following symptoms/issues? Circle all that apply.

Hearing Concerns	Vision Problems	Snoring	Chest Pain or Pressure
Difficulty Breathing	Constipation	Change in Urinary Habits	Chest Pain With Activity
Shortness of breath w/ exercise	Syncope (fainting)	Change in Bowel Habits	Weight Loss
Sleep disturbance	Fatigue	Excessive Thirst	Weight Gain
Limb Pain	Cough	Wheezing	Rash
Dizziness/Lightheadedness	Numbness		

Allergies? *No / Yes* _____

Medications? *No / Yes* _____

Past Medical History or Surgeries? *No / Yes* _____

Family History that could affect your child's healthcare? *No / Yes* _____

Has your child started menstruating? *Not applicable / No / Yes, started at age ___. Date of last period:* _____
The bleeding is (circle all that apply): *Regular / Irregular / Heavy / Light / Normal*
Cramping is (circle): *Light / Typical / Extremely painful*

Is a household family member currently deployed/on extended duty outside of the immediate area? *No / Yes*

Does the patient have exposure to secondhand smoke (vaping included)? *No / Yes*

Has your child traveled outside of the state in the last 21 days? *No / Yes* _____ Outside the US? *No / Yes*____

Any COVID exposures in the last 14 days? *No / Yes* _____

Is your child enrolled in EFMP? *No / Yes / Not yet but I think they should be*

(For Patients ages 9-11) – Has your child had lipid screening completed between ages 9-11? *No / Yes / Not sure*

What school will your child go to this fall? _____ What grade will they be in? _____

Turn Over

Answer the following if requesting sports clearance:

Has the patient been denied participation in activity due to medical reasons? *No / Yes*
Has the patient ever had chest pain while working out that made them stop exercising? *No / Yes*
Has the patient ever become dizzy and passed out during exercise? *No / Yes*
Is there a family history of early death before age 50? *No / Yes*
Is there a family history of any cardiac disease, Marfan syndrome, Long QT, congenital heart disease, dilated/hypertrophic cardiomyopathy or arrhythmias? *No / Yes*
Any history of concussions or bone fractures? *No / Yes*

Do you think your child is developing normally? *Yes / No*

Developmental Milestones (5-6 years)

	Yes	Not Yet
Speech is Clear and Understandable		
Counts to 10		
Draws a Person with at Least 6 Body Parts		
Copies a Triangle or Square		
Balances on One Foot for 10 Seconds		

Developmental Milestones (7-10 years)

	Yes	Not Yet
Does chores at home when asked		
Gets along with family & friends		
Engages in after-school activities		
Reading & doing math at grade level		
Eats healthy food and snacks		
Has positive self-image		

(For Patients ages 11-18) – Please have your child **complete the remainder of the form on their own.**

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Feeling down, depressed, irritable, or hopeless

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

Little interest or pleasure in doing things

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

Have you had any thoughts of hurting yourself or others? *No / Yes*

Return Form to Front Desk

Vision: Right 20/ ___ Left 20/___ Bilateral 20/___ Glasses or Contacts? Y / N

Weight: _____kg Height: _____cm HR _____ RR _____ BP _____ Temp _____ Sat _____

Notes: