

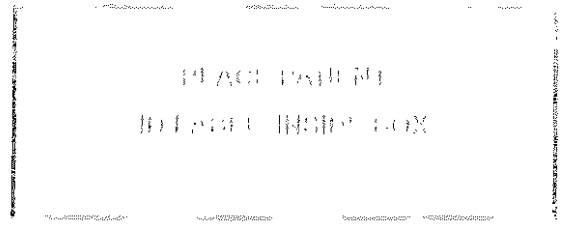


Rady Children's Hospital - San Diego  
 3020 Children's Way  
 San Diego, California 92123-4282

**Emergency Care Center  
 PATIENT INFORMATION  
 SHEET**



DT78630



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Parents/Guardians: Please help us provide the best possible care for your child by filling out this sheet as best you can.**

Allergies to medications (list drug and what happened): \_\_\_\_\_  None

Immunizations:  Up-to-date  Not up-to-date  Unsure

Missing immunizations: \_\_\_\_\_

Regular physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Current medications and doses: \_\_\_\_\_  None

What illnesses has your child been exposed to recently?: \_\_\_\_\_

Other common infections? \_\_\_\_\_  None

Major Illnesses/Conditions: \_\_\_\_\_  None

Previous Surgeries: \_\_\_\_\_  None

Overnight hospital stays (give age and reason why): \_\_\_\_\_  None

Who are the patient's main caretakers?  Mother  Father  Self  Other \_\_\_\_\_

Who is the legal guardian? \_\_\_\_\_ Who else lives at home? \_\_\_\_\_

Does the patient attend day care?  Yes  No Does anyone in the house smoke?  Yes  No

Do any of the following conditions run in the family? **Yes No** What relative?

Seizures (epilepsy)   \_\_\_\_\_

Asthma   \_\_\_\_\_

Diabetes   \_\_\_\_\_

Heart problems   \_\_\_\_\_

High blood pressure   \_\_\_\_\_

Migraines   \_\_\_\_\_

Other serious childhood illness   \_\_\_\_\_

Deaths in childhood   \_\_\_\_\_

**Has the patient had any of the following symptoms in the last 48 hours? (Please check YES or NO)**

	Yes	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Eye discharge	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	NO
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Increased drinking	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising/bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Limb pain	<input type="checkbox"/>	<input type="checkbox"/>

The information above is complete and accurate to the best of my knowledge.  
 PARENT / GUARDIAN SIGNATURE

I have reviewed the above information and made revisions where appropriate.  
 PHYSICIAN SIGNATURE

Date: \_\_\_\_\_

Date/Time: \_\_\_\_\_