Rady Children's

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

DT78630

Emergency Care Center
PATIENT INFORMATION SHEET

PLACE PATIENT IDENTIFICATION BOX

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		Yes	NO
Fever	❑	❑			
Ear pain	❑	❑	Rash	❑	❑
Runny Nose	❑	❑	Depression	❑	❑
Eye discharge	❑	❑	Painful urination	❑	❑
Sore throat	❑	❑	Increased drinking	❑	❑
Cough	❑	❑	Easy bruising/bleeding	❑	❑
Chest pain	❑	❑	Seizure	❑	❑
Vomiting	❑	❑	Limb pain	❑	❑
Diarrhea	❑	❑			
Constipation	❑	❑			

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

_____ Date: _____

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

_____ Date/Time: _____