Patient Name: _____

MR #:_____

Creek General Hospital (Multidisciplinary form)

Initial Assessment Form (to be filled for initial patients only)

For the Department of Pediatrics (to be filled by Doctor)

Date: _____ Weight: _____ (Kg) Pulse: _____/min. Height _____cm OFC _____

BP_____ mmHg Temperature: _____C Respiration _____ / min MUAC _____

Patient Age (Yrs.) _____	Allergies Yes ☐ No ☐	Patient at risk of fall Y/N
Gender:	If yes please specify _____	HEP B or C positive Y/N
Vaccination: Hep B ☐	_____	**Primary Physician Name & Designation**
Childhood vaccination ☐	History of blood transfusion Y/N	

PRESENTING COMPLAIN & HISTORY OF PRESENTING ILLNESS

BIRTH HISTORY:	**FEEDING HISTORY**
Antenatal	
Natal	
Postnatal	

HISTORY OF PAST ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ TB

DEVELEOPMENTAL HISTORY: _____

_____

FAMILY HISTORY: _____

_____

PERSONAL HISTORY _____

_____

ABDOMINAL EXAMINATION	**RESPIRATORY EXAMINATION**

CRDIOVASCULAR EXAMINATION	NEUROLOGICAL EXAMINATION

SYSTEMIC REVIEW: if patient currently have any of the following symptoms or conditions (Check yes)

General: ☐ Nothing in this group
☐ Weight loss – How much_____lbs.
☐ Loss of Appetite
☐ Fever
☐ Night Sweats
☐ Fainting Spells

Skin: ☐Nothing in this group
☐ Rash
☐ Bruising
☐ yellowing of the skin
☐ Eczema, psoriasis, other _____

Endocrine: ☐Nothing in this group
☐ Heat or cold intolerance
☐ Excessive thirst
☐ Polyuria

Digestive: ☐ Nothing in this group
☐ Loss of appetite
☐ weight Loss
☐ Dysphagia
☐ Flatulence
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in stool
☐ Reflux
☐ Abdominal pain

Urinary: ☐ Nothing in this group
☐ Burning micturition
☐ Dribbling
☐ Hematuria
☐ Retention
☐ Dysurea
☐ swelling of face
☐ incontinence

Cardiovascular: ☐ Nothing in this group
☐ Breathlessness
☐ Palpitations
☐ Edema
☐ Dizziness
☐ Fainting

Respiratory: ☐ Nothing in this group
☐ Chronic cough
☐ hemoptysis
☐ Breathlessness
☐ Hoarseness
☐ Wheezing
☐ Epistaxis
☐ Bronchitis
☐ Pneumonia

Musculoskeletal: ☐ Nothing in this group
☐ Joint pain
☐ Joint Stiffness
☐ Muscle weakness

NEONATAL EXAMINATION
GESTATINAL AGE BY DATE:
APGAR 1 min _____ 5 min _____
HEART RATE: _____
WEIGHT: _____ Ibs
LENGTH _____CM

GENERAL APPERANCE:
HEAD:
ANTERIOR FRONTELLE:
EYES
EARS
GENITALIA
CVS

NOSE:
NECK
ABDOMEN
LIMBS
CHEST
SPINE
ANUS

IF ANY DEFORMITY SPECIFY: _____

CNS 1. Moro Reflex: _____ 2. Grasp Reflex _____ 3. Rooting Reflex _____
4. Sucking reflex _____

PROVISINAL DIAGNOSIS AND TREATMENT PLAN:

DOCTOR NAME AND DESIGNATION _____