Cohen Children's Medical Center
Northwell Health

*General Pediatrics*

# Help Us Coordinate Your Care

Date: _____ Name: _____ DOB: _____
Reason For Your Visit: _____
Preferred Pharmacy: _____ City/State_____ Phone ( ) _____
*If you do not have a preferred pharmacy, please inform us and we can locate one for you.*

**1) Since your last visit to our office, was your child seen in the ER/Urgicenter or admitted to the hospital?**
❒ Y ❒ N
If yes, please write where and when: _____

**2) Since your last visit to our office, has your child seen any other doctors?**
❒ Y ❒ N
If yes, who did you see and when: _____

**3) Since your last visit to our office, has your child had any medical tests?** (Blood tests, X-rays, MRI, CT-scan)
❒ Y ❒ N
If yes, please explain type, where and when the tests were done: _____
_____

**4) Since your last visit to our office, has your child developed any new allergies or had a bad reaction to a medication, substance or food?**
❒ Y ❒ N
If yes, describe: _____

**5) Since your last visit to our office, has your child started any new prescribed or over the counter medications? Were there any problems with these medications?** (i.e. cost of medications, side effects, etc)
❒ Y ❒ N
If yes, list: _____

**6) What is the child's living situation if not with both biological parents?**
❒ Lives with adoptive parents ❒ Joint Custody ❒Single Custody ❒ Lives with foster family
If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?
_____

**7) Has anything changed with the health of your family members (parents, grandparents, siblings) since your last visit?**
❒ Y ❒ N
If yes, please list: _____

**8) Does anyone in your household smoke (parents, grandparents, siblings, babysitters/caregivers)?**

❒ Y ❒ N

If yes, please list: _____

**9) Which of the following topics regarding you or your child's health would you like to discuss today?**

Patient Issues: ❒Breathing Issues ❒Allergies ❒Weight management ❒Physical activity ❒Nutrition ❒Dental ❒Anxiety/Depression ❒Development

**Parental Issues:** ❒Breastfeeding ❒Parenting ❒Smoking cessation

❒Other_____

**What result(s) would you like to achieve:**

_____

_____

**Barriers that may prevent you or your child from reaching goal:** ❒None ❒Housing ❒Behavioral ❒Lack of Understanding ❒Access to Medications ❒Transportation ❒Cultural ❒Financial

❒Other_____