NAME **DATE**
AGE **MR**

What is the name and address of the doctor who asked you to bring your child to see us?

_____
_____
_____

What is the name and address of your pediatrician?

_____
_____
_____

Please list any medical problems your child sees a doctor for.

_____
_____
_____

Please list any surgeries your child has had in the past.

_____
_____
_____

Please list the medications your child is taking.

_____
_____
_____

Please list any allergies your child has to medication.

_____
_____
_____

Please check any medical problems that run in your family. (family history)

Ear Infections		Heart Disease		Easy Bleeding/Bruising		Problems with Anesthesia	
Allergies/Hay Fever		Cancer		Cystic Fibrosis		Thyroid Disease	
Asthma		Diabetes		Immune Disorders		Hearing loss	
Acid Reflux		Kidney Disease		Sickle Cell Disease		Cleft Lip/Palate	

Social History

Is your child in day care? Y N
Is your child exposed to tobacco smoke? Y N
Does/Did your child use a pacifier? Y N
Do you have any pets? Y N

Is/Was your child breast fed? Y N For How Long? _____
Number of older brothers / sisters at home? _____/_____
Number of younger brothers / sisters at home? _____/_____
DOG CAT OTHER_____ INDOOR OUTSIDE

Review of Systems **Does your child currently have any of the following problems?**

General			**Skin**		
Weight Loss/Failure to gain weight	Y	N	Eczema	Y	N
Night Sweats	Y	N	**Neurological**		
Recurrent Fevers	Y	N	Seizures	Y	N
Eyes			**Psychiatric**		
Itchy Eyes	Y	N	Anxiety	Y	N
Watery Eyes	Y	N	Depression	Y	N
ENT			**Endocrine**		
Hearing loss	Y	N	Excessive tiredness	Y	N
Snoring	Y	N	Pregnancy	Y	N
Apnea(stops breathing at night)	Y	N	**Musculoskeletal**		
Bedwetting	Y	N	Joint pain/stiffness	Y	N
Restless sleep	Y	N	**Immunologic**		
Daytime sleepiness	Y	N	Recurrent infections	Y	N
Gasping/Choking during sleep	Y	N	Allergies	Y	N
Mouth breathing during the day	Y	N	**Hematological**		
Frequent sneezing	Y	N	Easy Bleeding/Bruising	Y	N
Itchy nose	Y	N	Past blood transfusions	Y	N
Frequent/Chronic clear nasal drainage	Y	N	Recurrent Nose Bleeds	Y	N
Chronic green/yellow nasal drainage	Y	N	**Gastrointestinal/GERD**		
Cardiac			Heartburn	Y	N
Heart Murmur	Y	N	Pain with swallowing	Y	N
Need for antibiotics prior to surgical			Coughing/Choking with swallowing	Y	N
(dental) procedures	Y	N	Frequent vomiting	Y	N
Respiratory			Hoarseness	Y	N
Asthma	Y	N	Feeling of a lump in the throat	Y	N
Chronic cough	Y	N	Frequent stomach aches	Y	N
Genitourinary			Sour taste in the mouth when waking up	Y	N
Recurrent urinary tract infections	Y	N	Frequent throat clearing	Y	N