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		Cieft 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
- Weight Loss/Failure to gain weight Y N
- Night Sweats Y N
- Recurrent Fevers Y N

Eyes
- Itchy Eyes Y N
- Watery Eyes Y N

ENT
- Hearing loss Y N
- Snoring Y N
- Apnea(stops breathing at night) Y N
- Bedwetting Y N
- Restless sleep Y N
- Daytime sleepiness Y N
- Gasping/Choking during sleep Y N
- Mouth breathing during the day Y N
- Frequent sneezing Y N
- Itchy nose Y N
- Frequent/Chronic clear nasal drainage Y N
- Chronic green/yellow nasal drainage Y N

Cardiac
- Heart Murmur Y N
- Need for antibiotics prior to surgical (dental) procedures Y N

Respiratory
- Asthma Y N
- Chronic cough Y N

Genitourinary
- Recurrent urinary tract infections Y N

Skin
- Eczema Y N

Neurological
- Seizures Y N

Psychiatric
- Anxiety Y N
- Depression Y N

Endocrine
- Excessive tiredness Y N
- Pregnancy Y N

Musculoskeletal
- Joint pain/stiffness Y N

Immunologic
- Recurrent infections Y N
- Allergies Y N

Hematological
- Easy Bleeding/Bruising Y N
- Past blood transfusions Y N
- Recurrent Nose Bleeds Y N

Gastrointestinal/GERD
- Heartburn Y N
- Pain with swallowing Y N
- Coughing/Choking with swallowing Y N
- Frequent vomiting Y N
- Hoarseness Y N
- Feeling of a lump in the throat Y N
- Frequent stomach aches Y N
- Sour taste in the mouth when waking up Y N
- Frequent throat clearing Y N