

Pediatric History

NAME _____ Date of birth _____ Today's date _____

Prescriptions & doses: NONE _____ Pediatrician _____ ph# _____

_____ Person who sent you _____

_____ Local pharmacy _____ ph# _____

Other medications (such as Aspirin, Motrin, vitamins): NONE _____

Drug allergy: NONE KNOWN _____

List previous surgeries (date): NONE tonsils _____ adenoids _____ vent tubes _____ circumcision

other _____

Child's weight _____ lbs Child's height _____ Social history: Is this child in daycare? YES NO
Any speech or special learning classes? YES NO How many other children in family? _____

Does your child have any of the following problems? (Please answer every question.)

Constitutional

FEVER / CHILL YES NO
PREMATURE BIRTH YES NO
DELAYED SPEECH YES NO
SLOW GROWTH YES NO
BIRTH DEFECT YES NO
LEARNING PROBLEM YES NO
BEHAVIOR PROBLEM YES NO

Ear, Nose & Throat

HEARING LOSS YES NO
EAR PAIN YES NO
EAR DRAINAGE YES NO
NASAL BLOCKAGE YES NO
NOSEBLEEDS YES NO
CHRONIC RUNNY NOSE YES NO
MANY SINUS INFECTIONS YES NO

Cardiovascular

HEART MURMUR YES NO
RHEUMATIC FEVER YES NO

Respiratory

DIFFICULTY BREATHING YES NO
ASTHMA YES NO
LOUD SNORING YES NO
COUGH YES NO
HOARSENESS YES NO

Gastrointestinal

DIFFICULTY SWALLOWING YES NO
NAUSEA / VOMITING YES NO
REFLUX YES NO

Renal

URINARY INFECTIONS YES NO

Hematological / Lymphatic

BLEEDING DISORDER YES NO
SWOLLEN GLANDS YES NO
EASY BRUISING YES NO

Allergy/Immunology

SNEEZING OFTEN YES NO
ITCHY NOSE YES NO
ALLERGY TESTING YES NO
React to _____

Skin

ECZEMA YES NO

Eyes

LAZY EYE YES NO
VISUAL LOSS YES NO

Neurology

SEIZURE YES NO
ADD/ADHD YES NO
FREQUENT HEADACHES YES NO
CAR SICKNESS YES NO

Musculoskeletal

MUSCULAR WEAKNESS YES NO

Family History

ALLERGIES YES NO
BLEEDING DISORDER YES NO
HEARING LOSS YES NO
MIGRAINE HEADACHES YES NO

Any other medical problems _____

Reviewed by _____ Date _____ Reviewed by _____ Date _____