**Thank you in advance for answering a few questions to help us care for your child.**

**Please bring this to your appointment along with a Photo ID and Insurance card(s).**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason For Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and/or Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy (name and location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any allergies to medications, foods or the environment? **Y N**

If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications your child is currently taking (Including: Name, Dose, How many times per day):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

List any current medical conditions your child is being treated for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History (Including: Name, Date, and Surgeon): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth History (delivery method, weeks gestation, weight): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**SOCIAL HISTORY**

Does your child go to school? **Y N** Name of school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_

What activities does your child enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who currently lives in the household with the patient? (Please include pets): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there second hand smoke in the home? Y N Does the patient smoke? Y N

**REVIEW OF SYSTEMS – Check symptoms or problems your child has now or recently has had.**

**General**  **Genitourinary**

\_\_\_\_Fever \_\_\_\_Pain/burning on urination

\_\_\_\_Chills \_\_\_\_Blood in urine

\_\_\_\_Nights sweats \_\_\_\_Straining/trouble urinating

\_\_\_\_Fainting \_\_\_\_Mass or bulge in groin area

\_\_\_\_Dizziness \_\_\_\_Mass or swelling of breast

\_\_\_\_Unusual weight loss/gain \_\_\_\_Male – scrotal pain

\_\_\_\_Fatigue/unusually tired

\_\_\_\_Change in appetite **Musculoskeletal**

**Eyes**

\_\_\_\_Vision changes \_\_\_\_Joint pain/swelling/stiffness

\_\_\_\_Blurred vision \_\_\_\_Muscle pain/cramps/aches

\_\_\_\_Dry/sore eyes \_\_\_\_Muscle weakness

\_\_\_\_Discharge \_\_\_\_Spine deformity

\_\_\_\_Redness \_\_\_\_Bone deformity

**Ears, Nose, Throat** **Respiratory**

\_\_\_\_Earaches

\_\_\_\_Hearing loss \_\_\_\_Shortness of breath

\_\_\_\_Nose bleeds \_\_\_\_Wheezing

\_\_\_\_Nasal discharge \_\_\_\_Asthma

\_\_\_\_Trouble swallowing \_\_\_\_Frequent of chronic cough

\_\_\_\_Painful/sore throat \_\_\_\_Pain in chest when breathing

**Gastrointestinal** **Cardiovascular**

\_\_\_\_Abdominal pain \_\_\_\_Heart murmur

\_\_\_\_Nausea \_\_\_\_Rapid heart beat

\_\_\_\_Vomiting \_\_\_\_Heart anomaly

\_\_\_\_Abdominal swelling/bloating \_\_\_\_Chest pain

\_\_\_\_Abdominal mass

\_\_\_\_Diarrhea

\_\_\_\_Constipation

 **Skin**

\_\_\_\_Change in stool color \_\_\_\_Rash/redness

\_\_\_\_Bloody stool \_\_\_\_Itching

\_\_\_\_Use of laxatives/enemas \_\_\_\_Tenderness/pain

\_\_\_\_Skin eruption, drainage, pus

Hematologic/Lymphatic

\_\_\_\_Anemia

\_\_\_\_Easy/frequent bruising Neurologic

\_\_\_\_Prolonged/frequent bleeding \_\_\_\_Loss of sensation/numbness

\_\_\_\_Slow healing of wounds \_\_\_\_Dizziness

\_\_\_\_Seizures

Endocrine \_\_\_\_Paralysis

\_\_\_\_Increased/frequent thirst \_\_\_\_Speech difficulty

 \_\_\_\_Migraines/Headaches

\_\_\_\_Excessive sweating

\_\_\_\_Diabetes **Psychiatric**

\_\_\_\_Thyroid problems \_\_\_\_Anxiousness/stress

\_\_\_\_Depression

 \_\_\_\_Panic attacks

 \_\_\_\_Mood changes

 \_\_\_\_Sleep disturbances

 \_\_\_\_ADHD or ADD