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Last Name _____ First Name _____ Middle _____

DOB _____ Age _____ Height _____ Weight _____

Referring Doctor _____ Doctor's Phone _____

Why is your child seeing the doctor today? _____

****CHILD'S ALLERGIES: _____

PAST MEDICAL HISTORY: Has your child experienced any of the following problems:

Arthritis	Y N	Heart	Y N
Asthma	Y N	Hepatitis	Y N
Bleeding Problems	Y N	Lungs	Y N
Blood Pressure	Y N	Seizures	Y N
Cancer	Y N	Skin Problems	Y N
Chicken Pox	Y N	Stomach Problems	Y N
Diabetes	Y N	Thyroid	Y N
Enuresis (Bedwetting)	Y N	Mental Illness	Y N

Please list any serious illnesses or injuries and dates:

Illness/Injury _____ Year _____
Illness/Injury _____ Year _____

Please list **physician that treated the problem** you indicated above:

PAST SURGICAL HISTORY: Please list all surgeries and dates:

Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____

Indicate the **type(s) of anesthesia** received in the past and list any complications/reactions the child experienced.

Local Anesthesia: _____

General Anesthesia: _____

FAMILY HISTORY:

Please check the appropriate box if any of the following disorders are found in your family:

- Bleeding problems/Prolonged bleeding
- Problems with anesthesia or sedation
- Cancer (type: _____)
- Genetic disorders or Syndromes
- Sickle cell anemia or sickle cell trait
- Asthma/Allergies
- Other

Please specify if any of the above were checked and indicate blood relative with the problem:

List siblings, their age, and health status:

SOCIAL HISTORY: this form is for children up to 18 years of age-what does not apply to your child, do not complete

How active is your child: _____

Has your child EVER smoked cigarettes? Y N Packs/day? _____ Years? _____

Has your child STOPPED smoking? Y N Date? _____

Does anyone in the house smoke? Y N Who: _____

Does your child drink 3 cups of caffeine a day? Y N

Does your child have regular periods? Y N Age started period: _____

How many children does your child have? _____

MEDICATIONS: Please circle drugs your child is taking:

Aspirin/Anacin	Y N	Weight Reduction	Y N
Bufferin	Y N	Insulin	Y N
Motrin	Y N	Blood Thinners	Y N
Ibuprofen	Y N	Antibiotics	Y N
Arthritis Medicine	Y N	Birth Control	Y N
Asthma Meds	Y N		

Other Meds/Vitamins/Supplements and Doctor who prescribed each: _____

DRUGS/SUBSTANCES TO WHICH YOUR CHILD IS ALLERGIC:

Is your child allergic to: Latex: No Yes Surgical Tape: No Yes

REVIEW OF SYSTEMS

Please check the appropriate box if your child has any of the following:

Birth History

- Prematurity: _____ weeks early
- C-Section
- Apnea monitor

Skin

- Rashes
- Itching
- Dryness
- Lesions
- Acne

HEENT

- Abnormal head shape
- Vision changes
- Dizziness
- Hearing problems
- Headaches
- Sinus problems
- Nose bleeds
- Neck pain

Cardiovascular

- Heart defect
- Heart murmur
- Rapid heart beat
- Fainting

Respiratory

- Asmtha/wheezing
- Croup
- Chronic bronchitis
- Cystic fibrosis
- Shortness of breath

Gastrointestinal

- Gastro-esophageal reflex
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Hepatitis
- Intestinal/bowel problems
- Black or bloody stools

Genitourinary

- Urgency of urination
- Frequency of urination
- Pain with urination

Genitourinary (cont.)

- Incontinence
- Blood in urine
- Vaginal discharge

Neurological

- Convulsion, seizures
- Cerebral palsy
- Hydrocephalus
- Down's syndrome
- Myelomeningocele
- Developmental delay
- Speech or memory difficulties
- Numbness/tingling

Musculoskeletal

- Muscle pain
- Bone disease
- Joint pain
- Rheumatoid arthritis

Endocrine

- Hair loss
- Intolerance to heat/cold
- Diabetes

Psychiatric

- Impulsive behavior
- ADD/ADHD
- Depression/anxiety

Hematologic/lymphatic

- Frequent or easy bruising
- Excessive bleeding
- HIV positive
- Sickle cell disease/trait
- enlarged lymph nodes

OTHER:
