

Date _____

Patient's Name _____ Sex _____ Phone _____

Birth History

DOB _____
Birth Hospital _____
Birth Weight _____
Pregnancy Complications _____
Delivery Complications _____

Past Medical History

Allergies _____
Medications _____
Hospitalization _____
Surgery _____

Notes: _____

Social History

Mother's Name _____ Marital Status M S Remarried
Occupation _____ Age _____
Father's Name _____ Marital Status M S Remarried
Occupation _____ Age _____
Siblings' Names and Ages _____

Family History

Circle any medical conditions that run in your immediate family

Anemia, Asthma, Allergies, Diabetes, High Blood Pressure, Heart Trouble, Mental Illness, Inherited Illness, Cancer, Tuberculosis, Drug Problems, Alcohol Problems

List any others: _____

Development

Are you concerned about your child's behavior or development? Yes No
Does your child have problems in school? Yes No
If yes explain: _____

Safety

Does your child use his/her seat belt or car seat (under age 8) Yes No
Does your child use his/her bicycle helmet? Yes No
Is there a swimming pool? Yes No
Are there smokers in the household? Yes No
Are there firearms in the house? Yes No
Are there any pets in the house? Yes No

Immunizations

Do you have records of your child's immunizations? Yes No
Is it up to date? Yes No

Health Care Maintenance

Is your child currently in good health? Yes No
If no, explain _____
Do you have any concerns about your child? Yes No
If yes, explain _____

REVIEW OF SYSTEMS

Patient's Name: _____ Date: _____

Date of Birth: _____

EYE, EAR, NOSE, THROAT

Vision Problems	Y	N
Bleeding Gums	Y	N
Earache	Y	N
Ear discharge	Y	N
Allergies	Y	N
Hoarseness	Y	N
Loss of hearing	Y	N
Frequent ear infection	Y	N
Sinus problems	Y	N
Frequent nosebleeds	Y	N
Difficulty talking	Y	N
Stuttering	Y	N
Dental problems	Y	N
Sores in mouth/gums	Y	N
Frequent tonsil infection	Y	N
Tendency to breathe through mouth	Y	N

GENERAL

Excessive thirst	Y	N
Mark increase or decrease in appetite	Y	N
Persistently tired	Y	N
Slow heals scrapes, cut, wounds	Y	N
Recurrent fever	Y	N
Chills	Y	N
Depression	Y	N

Fever	Y	N
Loss of weight	Y	N
Sweats	Y	N
Unusual sensitivity to heat or cold	Y	N

GASTROINTESTINAL

Stomach aches	Y	N
Diarrhea	Y	N
Constipation	Y	N
Nausea or vomiting	Y	N
Worms	Y	N
Bloody or very dark stool	Y	N
Food restriction/dieting	Y	N

GENITOURINARY

Urination Problems	Y	N
Frequent Urination	Y	N
Painful, burning urination	Y	N
Blood in urine	Y	N
Bed-wetting problems	Y	N
Discharge from vagina or penis	Y	N

HEART

Heart Murmur	Y	N
Hypertension	Y	N
Chest Pain	Y	N
Irregular Heart Beat	Y	N
Must sleep propped up in bed	Y	N

Difficulty Breathing	Y	N
Wheezing	Y	N
Recurrent cough	Y	N
Shortness of breath	Y	N
Night-time cough	Y	N

MUSKOSKELETAL

Painful swollen joints	Y	N
Posture Problems	Y	N
Sprains	Y	N
Dislocations	Y	N
Broken bones	Y	N

NERVOUS SYSTEM

Dizzy or fainting spells	Y	N
Convulsions, seizures	Y	N
Tremors	Y	N
Difficulty walking, balancing or handling objects	Y	N

SKIN

Eczema/ skin problems	Y	N
Slow healing bruises	Y	N
Persistent rashes	Y	N
Hives	Y	N
Changing mole	Y	N

SOCIAL

School problems	Y	N
Parental divorce or separation	Y	N
Death in Family	Y	N
Use of alcohol, drugs or cigarettes	Y	N
Daycare	Y	N
How many days/ week		_____