PEDIATRIC PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth _____

PAST MEDICAL HISTORY/HISTORY OF PRESENT ILLNESS

What is the medical problem which brought your child here today?

How long has this been a problem?

How frequently does this occur?

What makes it better?

What makes it worse?

Please circle if the child has or has had any of the following conditions:

Asthma	Allergies	Heart Disease	Sickle Cell Disease	Seizures
Hepatitis	Reflux	Thyroid Disease	Pituitary Disease	AIDS
Leukemia	Free Bleeding	Lymphoma	Severe Head Injury	ADD/ADHD
Glaucoma	Diabetes	Growth Delay	Premature Birth	

Any other significant medical problems/hospitalizations?

Please list all surgical procedures not mentioned above and approximate dates:

Is the child allergic to any medications? (Circle) Yes No
Please list any drug allergies:

FAMILY HISTORY

Has anyone in the child's immediate family had (circle all that apply):

Allergies	Excessive bleeding	Hearing loss before age 40	Stroke before age 60
Asthma	Complications due to anesthesia	Heart Attack before age 50	Cancer before age 60

SOCIAL HISTORY

This child is in (circle): Day Care School Neither

Does any parent or caregiver smoke? Yes No

Does the child have more or ever had a significant problem with (Circle all that apply):

- Significant recent weight change
- Unexplained fevers
- Ear Pain
- Hearing Loss
- Drainage from ear
- Bleeding from ear
- Spits up frequently
- Chronic diarrhea
- Excessive sneezing
- Headaches
- Poor balance
- Can't breathe well
- Pain in nose
- Bleeding from nose
- Discolored drainage
- Free bleeding
- Lump in neck or armpit
- Skin rashes or hives
- Eye injury
- Double vision
- Enlarged tonsils
- Hoarseness
- Difficulty swallowing
- Currently under psychiatric are
- Easy bruising
- Itchy eyes
- Any heart abnormality

- Chronic Cough - Shortness of breath - Wheezing

LIST OF CURRENT MEDICATIONS

Name: _____ Date: _____

Medication (Brand and/or Generic Name)	Dose	How often do you take the medication?

List any medication allergies:

_____

_____

_____