 PLEASE PRINT

►► **PATIENT'S NAME: ___________________________ ACCT# ______**

Please read and answer each question carefully by filling in or circling in INK.

HAS YOUR CHILD HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

Back Problems	YES	NO
Blood Disorders	YES	NO
Cancer	YES	NO
Depression	YES	NO
Diabetes	YES	NO
Endocrine/Hormonal	YES	NO
Environmental Allergies	YES	NO
Gastrointestinal (Reflux/Ulcers)	YES	NO
HIV	YES	NO
Hearing Loss	YES	NO
Heart Disease	YES	NO
Hepatitis	YES	NO
High Blood Pressure	YES	NO
Infectious Disease/MRSA	YES	NO
Language/Articulation	YES	NO
None	YES	NO
Pulmonary Problems	YES	NO
Seizure Disorders	YES	NO
Sinusitis	YES	NO
Stroke	YES	NO
Thyroid Disease	YES	NO
Vertigo/Dizziness	YES	NO

DOES YOUR CHILD CURRENTLY HAVE ANY OF THE PROBLEMS LISTED BELOW:

(circle all that apply)

Neurological:
Headaches
Weakness
Numbness
Fainting

Cardiovascular:
Chest Pain
Abnormal Heart Beat

Muscular/Skeletal:
Muscle Aches
Joint Aches

Respiratory:
Shortness of breath
Cough

Psychological:
Depression
Anxiety

Dermatologic:
Rash
Itchy skin

General:
Fatigue
Weight Loss
Weight Gain
Fever/Chills

Gastrointestinal:
Constipation
Diarrhea
Heartburn
Abdominal Pain

Urinary:
Difficulty urinating
Frequent urination

ENT:
Blurry vision
Sneezing
Itchy eyes
Noise in ears
Hearing loss
Dizziness
Earache
Difficulty Swallowing
Hoarseness
Bleeding nose
Sore throat

Please explain any problems you answered YES:

____

____

____

Please explain any other medical problems not listed above:

____

____

allergic to any medications? YES NO

Medications child is allergic to: ____

Allergic to latex? YES NO If yes- reaction: ________________________

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Does your child take any medications? (include prescription, over-the-counter, and drops, sprays, vitamins and herbal supplements)

NAME	DOSAGE	HOW OFTEN?

LIST ANY SURGICAL PROCEDURES YOUR CHILD HAS HAD BELOW:

Type of Surgery	Date/Year

FAMILY HISTORY

PLEASE CIRCLE IF ANYONE IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING:

Bleeding Disorder	YES	NO	
Cancer	YES	NO	type of cancer: ____________________________
Diabetes/Hypoglycemia	YES	NO	
Hearing Loss	YES	NO	
Cardiac/Heart Disease	YES	NO	
High Blood Pressure	YES	NO	
Stroke	YES	NO	
Thyroid Disease	YES	NO	

Other ____________________________________

PEDIATRIC HISTORY (circle all that apply)

Prenatal/Birth History: Premature: ***Y N*** *if yes # of weeks____.* **Stay in NICU:** ***Y N*** *if yes # of weeks___.* **Intubated:** ***Y N*** *if yes # of weeks ___*

Passed Universal Newborn Hearing Screening Y N

Normal Growth: Y N
Normal Development: Y N **Normal Speech/Language Development: Y N**

Child lives with: *Mother Father Step-Mother Step-Father Grandparent Guardian Brothers Sisters other ___________________*

Is Child in Daycare Yes No **How many days per week? ________**

If child is in school- What Grade ________ *Excellent Grades Average Grades Poor Grades*

Does anyone smoke in your home? *Yes No*
Are your child's immunizations up to date? *Yes No*