

I have reviewed both sides of this medical history form. Physician Signature: _____

(Nurse to Complete: Weight: _____ Temp: _____ Pulse: _____ Respiration: _____)

New or Updated Children & Adolescent Patient Medical History (16 years or younger)

In order for you to receive high quality care, **please answer all questions.** (Update Required Every Year.)

Name: _____ Date of Birth: _____ Your Primary M.D. _____

Date Form Filled Out: _____ Date of Appt: _____ Child's Age: _____

Which Physician Outside Of Our Group Sent You to Our Office For This Consultation (Office Visit)?: _____
(Physician First and Last Name)

Briefly, what are you seeing the physician about today? Have you been seen for this problem before? If so, when and by whom?:

HAVE YOU RECENTLY SEEN ANOTHER PHYSICIAN FOR THIS CURRENT ILLNESS? YES NO

REVIEW OF SYSTEMS

INDICATE BELOW THE SYMPTOMS **YOUR CHILD IS CURRENTLY HAVING:**

1. GENERAL:	YES	NO	6. MOUTH:	YES	NO
A. Fatigue	_____	_____	A. Lesions	_____	_____
B. Weight Loss	_____	_____	B. Loss of Taste	_____	_____
C. Fevers	_____	_____	7. THROAT:		
D. Chills	_____	_____	A. Frequent Sore Throat	_____	_____
E. Nausea	_____	_____	B. Laryngitis	_____	_____
F. Headaches	_____	_____	C. Cough	_____	_____
2. SKIN:			D. Difficulty Swallowing	_____	_____
A. Lesions	_____	_____	8. NECK:		
3. EYES:			A. Pain and/or Lumps	_____	_____
A. Double Vision	_____	_____	B. Persistent Lymph Nodes	_____	_____
B. Blurred Vision	_____	_____	9. ALLERGIC:		
C. Loss of Vision	_____	_____	A. (circle)		
4. EARS:			Itchy eyes, ears,		
A. Hearing Loss	_____	_____	nose, palate	_____	_____
B. Exposure-Loud Noises	_____	_____	B. Watery Eyes	_____	_____
C. Drainage	_____	_____	C. Scratchy Throat	_____	_____
D. Pain	_____	_____	D. Sneezing Excessively	_____	_____
E. Noise in Ears (Tinnitus)	_____	_____	10. BLOOD SYSTEM:		
F. Dizziness	_____	_____	A. Bleeding or Easy Bruising	_____	_____
G. Hearing Aids	_____	_____	11. STOMACH AND INTESTINES:		
5. NOSE:			A. Nausea and/or Vomiting	_____	_____
A. Bleeding	_____	_____	B. Indigestion, Heartburn	_____	_____
B. Facial Pain/Pressure	_____	_____	C. Abdominal Cramps	_____	_____
C. Congestion	_____	_____	12. LUNGS:		
D. Discharge	_____	_____	A. Shortness of Breath	_____	_____
E. Sneezing	_____	_____	B. Noisy Breathing	_____	_____
F. Snoring	_____	_____	C. Wheezing, Asthma	_____	_____
G. Mouth Breathing	_____	_____	D. Cough	_____	_____
H. Gasping or Breathing	_____	_____	13. HEART:		
Pauses When Asleep	_____	_____	A. Heart Murmur	_____	_____

CONTINUED ON BACK PAGE

Please Print Your Name on Top of Back Page

**New or Updated Children & Adolescent Patient Medical History
(16 years or younger)**

Patient Name: _____

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SOCIAL HISTORY

	Yes	No		Yes	No
Day Care/Pre-School	_____	_____	Bottle Fed as Infant	_____	_____
Family Smoking	_____	_____	Breast Fed as Infant	_____	_____
Is Your Child Adopted	_____	_____	Using Pacifier	_____	_____
Are Parents Divorced	_____	_____			

INDICATE BELOW ANY DISEASES YOUR CHILD MAY HAVE: (if yes, explain below)

	Yes	No		Yes	No
Eye Disease	_____	_____	Bleeding Tendency	_____	_____
Lung Disease	_____	_____	Rheumatic or Scarlet Fever	_____	_____
Heart Disease	_____	_____	Eczema	_____	_____
Kidney Disease	_____	_____	Diabetes	_____	_____
Urinary Disease	_____	_____	Frequent Infections (lungs, urinary,etc)	_____	_____
Thyroid Disease	_____	_____			

LIST ANY OTHER DISEASES YOUR CHILD MAY HAVE HAD:

SURGERIES: (List below any surgery your child has had):

PROBLEMS WITH GENERAL ANESTHESIA? (circle one) Yes No

ARE YOUR CHILD'S IMMUNIZATIONS CURRENT?: (circle one) Yes No

LIST THE CURRENT MEDICINES YOUR CHILD IS TAKING: (List with Dosage and Frequency)

KNOWN ALLERGIES TO: ENVIRONMENT: Yes No FOOD: Yes No

KNOWN ALLERGIES TO MEDICATION: Yes No (If yes, list below)

BIRTH HISTORY: (if abnormal, explain below)	Yes	No		Yes	No
Normal Full Term Pregnancy	_____	_____	ICU Hospitalization Immediately		
Normal Labor	_____	_____	After Birth	_____	_____
Normal Vaginal Delivery	_____	_____	Weight At Birth _____		

FAMILY HISTORY: INDICATE BELOW ANY DISEASE IN YOUR CHILD'S IMMEDIATE FAMILY (Parents, Brothers, Sisters)

	Yes	No		Yes	No
Hearing Loss	_____	_____	Allergies	_____	_____
Bleeding Abnormalities	_____	_____	Anesthesia Complications	_____	_____

LIST ANY ABNORMAL BIRTH DEFECTS OR BIRTH CONDITIONS: _____

The above information is correct.

Parent Signature: _____