



Child New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth ____/____/____

Parent or Guardian's Name: _____

Chief Complaint or Concern:

MEDICATIONS (including prescription and over-the-counter)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Does your child have any allergies to any medications? Yes No

If yes – please list:

PAST SURGICAL HISTORY

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Has your child ever had your tonsils and/or adenoids surgically removed? Yes No

ALLERGY HISTORY

None Known Yes, to: 1. _____ 3. _____
2. _____ 4. _____

Pets: No Yes How many? _____ What type of pet? _____

Do any pets sleep in your child's bedroom? No Yes

Which pets? _____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic insomnia |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Overweight/obesity | <input type="checkbox"/> Restless legs syndrome |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Snoring | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | |

REVIEW OF SYMPTOMS

Constitutional:

- Loss of Appetite: Yes No
- Fever: Yes No
- Fatigue: Yes No
- Weight Gain: Yes No
- Weight Loss: Yes No

Respiratory:

- Cough: Yes No
- Asthma: Yes No
- Wheezing: Yes No
- Poor Exercise Tolerance: Yes No

REVIEW OF SYMPTOMS

Gastrointestinal:

- Heartburn/Indigestion: Yes No
- Black or Bloody Stools: Diarrhea: Yes No
- Nausea/Vomiting: Yes No
- Jaundice: Yes No
- Abdominal Pain Yes No

Allergy/Immunology:

- Nasal allergies/Hay fever/
Nasal Congestion: Yes No
- Sneezing: Yes No
- Runny Nose: Yes No
- Itchy Eyes or Nose: Yes No
- Hives: Yes No

Eyes:

- Blurry Vision: Yes No
- Double Vision: Yes No
- Vision Loss : Yes No

Genitourinary:

- Frequent Urination Yes No
- Difficulty Urinating: Yes No
- Blood in Urine: Yes No

Musculoskeletal:

- Stiff/Sore Joints: Yes No
- Muscle Pain: Yes No
- Red or Swollen Joints: Yes No
- Temporomandibular Joint
(TMJ) pain/jaw discomfort: Yes No

Ears/Nose/Throat/Mouth:

- Hearing Loss: Yes No
- Sore Throat: Yes No
- Sinus Congestion: Yes No
- Hoarseness: Yes No
- Tubes in Ears: Yes No

REVIEW OF SYMPTOMS

Cardiac:

- Palpitations: Yes No
Chest Pain: Yes No
Daytime Shortness of Breath: Yes No
Nighttime Shortness of Breath: Yes No
Ankle Swelling: Yes No
Hypertension/High Blood Pressure Yes No

Skin:

- Unusual Moles: Yes No
Rash: Yes No
Dryness: Yes No

Endocrine:

- Heat Intolerance Yes No
Cold Intolerance: Yes No
Excessive Thirst: Yes No
Constipation: Yes No

Neurologic:

- Weakness: Yes No
Seizures: Yes No
Involuntary Tongue Biting: Yes No
Passing Out: Yes No
Dizziness: Yes No
Headaches: Yes No
Numbness: Yes No

Psychiatric:

- Excessive Stress: Yes No
Memory Loss: Yes No
Hallucinations: Yes No
Nervousness or Anxiety: Yes No
Depressed Mood: Yes No
Memory Loss: Yes No

Was your child breast fed? Yes No

If your child was breast fed – for how long? _____

Was your child Full Term Premature

If Premature – at how many weeks was your child delivered? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION