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HISTORY FOR PEDIATRICS

DATE ____________

LEGAL NAME ____________ SEX ____________

DATE OF BIRTH ____________ HEIGHT ____________ WEIGHT ____________

ALLERGIES TO MEDICATIONS ____________ **ALLERGIES TO LATEX?** ☐ YES ☐ NO

Please state briefly why your child is being referred to this office. (Please continue on back of page if needed).

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PAST MEDICAL HISTORY

HOSPITALIZATIONS ____________

SURGERIES ____________

URINARY TRACT INFECTIONS ☐ YES ☐ NO

BLOOD IN URINE ☐ YES ☐ NO

IMMUNIZATIONS UP-TO-DATE ☐ YES ☐ NO

FEVERS OF UNKNOWN ORIGIN ☐ YES ☐ NO

BED WETTING ☐ YES ☐ NO

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING SYMPTOMS?

PAIN WITH URINATION ☐ YES ☐ NO BLOOD IN THE URINE ☐ YES ☐ NO FEVER ☐ YES ☐ NO BACK PAIN ☐ YES ☐ NO

HAS YOUR CHILD RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL
- CHILLS ☐ YES ☐ NO
- FEVER ☐ YES ☐ NO
- WEIGHT LOSS ☐ YES ☐ NO

CARDIOVASCULAR
- CHEST PAIN ☐ YES ☐ NO
- HEART MURMUR ☐ YES ☐ NO
- PALPITATIONS (IRREGULAR HEARTBEAT) ☐ YES ☐ NO

HEENT
- BLURRED VISION ☐ YES ☐ NO
- DOUBLE VISION ☐ YES ☐ NO
- HEARING LOSS ☐ YES ☐ NO
- SOAR THROAT ☐ YES ☐ NO

HEMATOLOGIC/LYMPHATIC
- EASY BLEEDING ☐ YES ☐ NO
- LYMPHADENOPATHY (SWOLLEN LYMPH NODES) ☐ YES ☐ NO
- PETECHIAE (BRUISING) ☐ YES ☐ NO

RESPIRATORY
- CHRONIC COUGH ☐ YES ☐ NO
- DYSPNEA (SHORTNESS OF BREATH) ☐ YES ☐ NO
- KNOWN TB EXPOSURE ☐ YES ☐ NO
- WHEEZING ☐ YES ☐ NO

GENITOURINARY
- DYSURIA ☐ YES ☐ NO
- ERECTILE DYSFUNCTION ☐ YES ☐ NO
- HEMATURIA (BLOOD IN URINE) ☐ YES ☐ NO
- URINARY FREQUENCY ☐ YES ☐ NO
- URINARY INCONTINENCE ☐ YES ☐ NO
- URINARY RETENTION ☐ YES ☐ NO

GASTROINTESTINAL
- ABDOMINAL PAIN ☐ YES ☐ NO
- BLOOD IN STOOL ☐ YES ☐ NO
- CONSTIPATION ☐ YES ☐ NO
- DIARRHEA ☐ YES ☐ NO
- HEARTBURN ☐ YES ☐ NO
- LOSS OF APPETITE ☐ YES ☐ NO
- NAUSEA ☐ YES ☐ NO
- VOMITING ☐ YES ☐ NO

INTEGUMENTARY
- CONTACT ALLERGY ☐ YES ☐ NO
- HIVES ☐ YES ☐ NO
- ITCHING SKIN ☐ YES ☐ NO
- RASH ☐ YES ☐ NO

METABOLIC/ENDOCRINE
- EXCESSIVE THIRST ☐ YES ☐ NO
- FATIGUE ☐ YES ☐ NO
- HOT FLASHES ☐ YES ☐ NO

MUSCULOSKELETAL
- ARTHRITIS ☐ YES ☐ NO
- BACK PAIN ☐ YES ☐ NO
- JOINT PAIN ☐ YES ☐ NO
- NECK PAIN ☐ YES ☐ NO

NEUROLOGICAL
- DIFFICULTY WALKING ☐ YES ☐ NO
- HEADACHE ☐ YES ☐ NO
- MEMORY LOSS ☐ YES ☐ NO
- SEIZURES ☐ YES ☐ NO
- TREMORS ☐ YES ☐ NO

PSYCHIATRIC
- ANXIETY ☐ YES ☐ NO
- DEPRESSION ☐ YES ☐ NO
- INSOMNIA ☐ YES ☐ NO

IMMUNOLOGIC
- ASTHMA ☐ YES ☐ NO
- FOOD ALLERGIES ☐ YES ☐ NO
- OTHER: ____________

SOCIAL HISTORY

GRADE IN SCHOOL ____________ SCHOOL PROGRESS: *circle one* Excellent Good Poor AGE TOILET TRAINED ____________

ARE BROTHERS/SISTERS HEALTHY? ☐ YES ☐ NO HISTORY OF CHILD ABUSE? ☐ YES ☐ NO

BIRTH HISTORY

PROBLEMS DURING PREGNANCY ____________

MATERNAL DRUGS DURING PREGNANCY ____________

PERINATAL ILLNESSES ____________

FAMILY HISTORY

☐ URINARY TRACT INFECTIONS ☐ SICKLE CELL ☐ BLOOD IN THE URINE

☐ KIDNEY DISEASE ☐ BED WETTING ☐ OTHER: ____________

REMARKS:

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