

# 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