

DATE: _____

Patient Name: _____ **D.O.B.:** _____ **Age:** _____

Who is your child's primary care doctor? _____

Why is your child seeing the doctor today? _____

MEDICAL HISTORY (Circle Yes or No): Child's Height: _____ ft _____ in Weight: _____ lbs

Complications with pregnancy or delivery	Y N	Pre-Maturity	Y N	Urinary Tract Infections	Y N
Abnormal prenatal ultrasounds or exams	Y N	Unexplained Fevers	Y N	Bedwetting	Y N
Wets or Soils Underwear	Y N	Persistent Constipation	Y N	Known Medical Disease	Y N
Heart Problems	Y N	Lung Problems	Y N	Intestinal Problems	Y N
Nervous Disorder	Y N	Anesthesia Reaction	Y N		

REVIEW OF SYSTEMS:

Fever	Y N	Headache	Y N	Visual Changes	Y N	Dizziness/Lightheadedness	Y N
Fatigue	Y N	Nausea/Vomiting	Y N	Abdominal Pain	Y N	Chest Pains	Y N
Rash/Itching	Y N	Joint/Back Pains	Y N	Urinary problems	Y N	Blood in Urine	Y N
Cough	Y N	Wheezing	Y N	Shortness of Breath	Y N	Bleed Easily	Y N
Depressed/Sad	Y N	Swollen Glands	Y N	Extreme sensitivity to cold/heat	Y N		

FAMILY HISTORY: Birth Defects Y N Kidney, Bladder or Genital abnormalities Y N

Please elaborate on any "yes" answers (be as specific as possible): _____

SURGICAL HISTORY (Please list any surgeries your child has had and approximate date):

MEDICATIONS

1. _____ 2. _____ 3. _____

MEDICATIONS THAT CAUSE ALLERGIES (i.e.hives, rash, difficulty breathing)

Is your child allergic to iodine or seafood? Y N

1. _____ 2. _____ 3. _____

Does your child enjoy and participate normally in school or social activities? Y N If No, please explain:

Reviewed by: _____