

## PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

Child's Name: \_\_\_\_\_, Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: F \_\_\_\_\_ M \_\_\_\_\_

**SYMPTOMS: (mark C for current and P for past symptoms)**

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Excessive fatigue	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Excessive perspiration	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Anemia	<input type="checkbox"/> Flat feet	<input type="checkbox"/> No appetite
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Gas	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Parasites
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Body odour	<input type="checkbox"/> High fevers	<input type="checkbox"/> Rash
<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Hives	<input type="checkbox"/> Sensitive to light
<input type="checkbox"/> Canker sores	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Changes in appetite	<input type="checkbox"/> Itchy anus	<input type="checkbox"/> Stomach aches
<input type="checkbox"/> Congestion	<input type="checkbox"/> Itchy nose (or picks nose)	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Constipation	<input type="checkbox"/> Itchy vagina	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Cough	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Talks in sleep
<input type="checkbox"/> Cries easily	<input type="checkbox"/> Joint pains	<input type="checkbox"/> Walks in sleep
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Migraines	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Eczema		<input type="checkbox"/> Vomiting spells

For Office Use  
Only:

**MEDICAL HISTORY:**

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Dental problems	<input type="checkbox"/> Neural Tube Defect
<input type="checkbox"/> Allergies (environmental)	<input type="checkbox"/> Developmental problems	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Allergies (food)	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Rubella
<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Autism	<input type="checkbox"/> Impaired speech	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Croup	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other (specify):

Nutritional Supplements (please list). Include herbal and homeopathic as well.

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**MEDICATIONS.** Indicate length of time child received each medication.

<input type="checkbox"/> Antacids	<input type="checkbox"/> Declectin	<input type="checkbox"/> Methylphenidate (Ritalin)
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Decongestant	<input type="checkbox"/> Oral Steroids
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Dextroamphetamine (Dexedrine, Dextrostat, Adderall)	<input type="checkbox"/> Pemoline (Cylert)
<input type="checkbox"/> Anti-Histamine	<input type="checkbox"/> Epilepsy medication	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Others (please list)
<input type="checkbox"/> Clonidine	<input type="checkbox"/> Inhaled Steroids	

Are you aware of any allergies to medications?

**IMMUNIZATIONS:**

Diphtheria	Influenza	IPV (Polio)
DPT	Measles	PNEU (Pneumococcal disease)
Hemophilus	MENI (Menigococcal disease)	Small pox
Hepatitis	MMR (Measles, Mumps, Rubella)	Tetanus
Hib (Hemophilus Influenza)	Mumps	VAR (Varicella or chicken pox)

Were there any reactions to immunization(s)? If so, at what age?

**MOTHER'S HEALTH DURING PREGNANCY: (check all that apply)**

Alcohol, Cigarettes, Drug Consumption	Gestational Diabetes	Stress
Anemia	Hypertension	Thyroid problems
Bleeding	Nausea	Uterine infection
Dental problems	Physical or Emotional Trauma	Other:
Diabetes	Pre-eclampsia	

**MEDICATIONS WHILE PREGNANT:**

**MEDICATIONS WHILE NURSING (Mother):**

**TERM:**

Full \_\_\_ Premature \_\_\_ Late \_\_\_

Weight at birth \_\_\_\_\_ lb

**LABOR & DELIVERY:**

Was pregnancy induced?

Vaginal \_\_\_ C-Section \_\_\_ Complications during labor? \_\_\_\_\_

Medications during or after labor? \_\_\_\_\_

**FEEDING:**

Breast fed \_\_\_ Bottle fed \_\_\_

When was formula started?

When were solid foods first introduced?

What were the first foods introduced?

Did your baby have any of the following problems?

\_\_\_ Jaundice

\_\_\_ "Blue Baby"

\_\_\_ Colic

\_\_\_ Diarrhea

\_\_\_ Thrush