Please leave this form with the doctor

Patient Questionnaire

Child's Name ______________________________ Date of Birth __________

Please provide the following information regarding your child's medical history. This information will be entered into our computer system.

Past Medical History

Is your child allergic to any medications? YES NO
If yes, please specify medication and reaction ______________________________

Is your child allergic to any foods? YES NO
If yes, please specify food and reaction ______________________________

Has your child been overnight in a hospital (other than at birth)? YES NO
If yes, please specify when and why ______________________________

Has your child ever had surgery? YES NO
If yes, please specify when and what procedure ______________________________

Does your child take medications on a daily basis? YES NO
If yes, please specify medication dose and reason for taking ______________________________

Does your child have any ongoing medical problems (such as Asthma, ADHD or Seizures)? YES NO
If yes, please specify ______________________________

Review of Systems

Has your child had frequent ear infections? YES NO
Any eye problems? YES NO
Has he/she had any problems with teeth? YES NO
Is there asthma, pneumonia or recurrent cough? YES NO
Does he/she have a heart murmur or any heart problem? YES NO
Any problems with kidneys or bladder? YES NO
Any problems with constipation or diarrhea? YES NO
Have there been any convulsions or seizures? YES NO
Any eczema, hives or skin condition? YES NO
Has your child ever been anemic? YES NO

(OVER)

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Family History

Are the child's parents both in good health? YES NO

If no, please specify medical issues ______________________________

Is there a family history of any of the following illnesses?

If yes, please **SPECIFY** which family member is affected. Example: Grandma (mom's side), Grandpa (dad's side)

Anemia	YES NO	______________________
Asthma	YES NO	______________________
Allergies	YES NO	______________________
Diabetes (Type I or II)	YES NO	______________________
High Blood Pressure	YES NO	______________________
Heart Disease	YES NO	______________________
Mental Illness	YES NO	______________________
Drug Problems	YES NO	______________________
Alcohol Problems	YES NO	______________________
Cancer? Specify location	YES NO	______________________
Inherited Illness	YES NO	______________________
Seizures (with or without fever)	YES NO	______________________
Thyroid Disease (hyper or hypo)	YES NO	______________________

Are there any smokers living with your child? YES NO

(OVER)