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)

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

For Office Use Only:

MEDICAL HISTORY: (check all that apply)

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

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

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MEDICATIONS. (check all that apply, and indicate the length of time the child received each medication.)

❑ Antacids	❑ Declectin	❑ Methylphenidate (Ritalin)
❑ Antibiotics	❑ Decongestant	❑ Oral Steroids
❑ Antidepressants	❑ Dextroamphetamine Dexedrine, Dextrostat, Adderall	❑ Pemoline (Cylert)
❑ Anti-Histamine	❑ Epilepsy medication	❑ Tylenol
❑ Aspirin	❑ Ibuprofen	❑ Others (please list)
❑ Clonidine	❑ Inhaled Steroids	

Are you aware of any allergies to medications?

IMMUNIZATIONS: (check all that apply)

❑ Diptheria	❑ Influenza	❑ IPV (Polio)
❑ DPT	❑ Measles	❑ PNEU (Pneumoccocal 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 (specify):
☐ Diabetes	☐ Pre-eclampsia	

For Office Use Only:

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