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:

☐ 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. Indicate length of time 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:

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:
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