Todays Date: __________ Doctor you are seeing today: ______________________
Patient Name: ____
Date of Birth: _______________ Age: ______ Male: ☐ Female: ☐
Primary Care Physician: ______________________________________
Is there a Referring Physician or Provider? __________________________
If not referred by a doctor, how did you hear about our office? _______________
____
What is the primary reason for your visit with the doctor? ___________________
____
____

PHARMACY YOU WOULD LIKE TO USE:________________________________
____

PAST MEDICAL HISTORY	Yes	No
Does the patient have any medical problems?	☐	☐

Please List: ____
____
____

	Yes	No
HAS THE PATIENT EVER HAD CANCER?	☐	☐

If so, what type? ____
____

	Yes	No
HAS THE PATIENT HAD SURGERY?	☐	☐

Please List: ____
____
____

MEDICATIONS

Please list any medications that your child takes on a regular basis.
____
____
____

	Yes	No
LATEX ALLERGY	☐	☐
DRUG ALLERGIES	☐	☐

Please List: ____
____
____

SOCIAL HISTORY FOR CHILDREN:

Who is the primary care giver of your child (mother, father, grandparent etc)?
____

	Yes	No
Daycare	☐	☐
Does anyone smoke around your child?	☐	☐
Immunized	☐	☐

Update? __________________________

	Yes	No
Siblings	☐	☐

Ages ____
____
Health problems of siblings: ______________________________
____
____

FAMILY HISTORY

ANY FAMILY HISTORY OF THE FOLLOWING	Yes	No
Heart Disease	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Bleeding tendencies	☐	☐

Other: ____
____

REVIEW OF SYSTEMS

Does the child currently have any of the following symptoms?

CONSTITUTIONAL SYMPTOM	Yes	No
Fever/ Chills	☐	☐
Lethargy	☐	☐
Weight gain / loss	☐	☐

EYES	Yes	No
Blurred vision	☐	☐
Double vision	☐	☐

RESPIRATORY	Yes	No
Wheezing	☐	☐
Frequent cough	☐	☐
Shortness of breath	☐	☐
History of Asthma	☐	☐

CARDIOVASCULAR	Yes	No
Chest pain	☐	☐
Rhythm problem	☐	☐
High blood pressure	☐	☐

GASTROINTESTINAL	Yes	No
Abdominal pain	☐	☐
Nausea / vomiting	☐	☐
Indigestion / heartburn	☐	☐

NEUROLOGICAL	Yes	No
Dizzy spells	☐	☐
Numbness / tingling	☐	☐
Seizure history	☐	☐

ENDOCRINE	Yes	No
Excessive thirst	☐	☐
Too hot / cold	☐	☐
History of diabetes	☐	☐
Thyroid problems	☐	☐

HEMATOLOGIC / LYMPHATIC	Yes	No
Anemia	☐	☐
Blood clotting problem	☐	☐
Easy bruising	☐	☐
Swollen nodes	☐	☐
Had a transfusion?	☐	☐
History of Hepatitis?	☐	☐

ALLERGIC / IMMUNOLOGIC	Yes	No
Itchy eyes / nose	☐	☐
Runny nose	☐	☐
Pets in the home	☐	☐
Immune disorder	☐	☐
Pregnant?	☐	☐

DOES YOUR CHILD HAVE	Yes	No
Trouble sleeping?	☐	☐
Frequent awakening	☐	☐
Snoring	☐	☐
Mouth breathing	☐	☐
Restless legs	☐	☐
Restless sleep	☐	☐
Sleep walking	☐	☐
Sleep talking	☐	☐
Wetting the bed	☐	☐
Does your child have trouble eating or are they a finicky eater?	☐	☐

DOES YOUR CHILD HAVE	Yes	No
Sinus infections	☐	☐
How many per year? ________________		
Tonsil infections	☐	☐
How many per year? ________________		
Ear infections	☐	☐
How many per year? ________________		
Trouble hearing	☐	☐
How long? ________________________		
Speech difficulty	☐	☐
Reflux	☐	☐
Large tonsils	☐	☐
Failure to thrive	☐	☐

HT/WT: _________________________ BP: ________________
TEMP: _________________ PULSE: _______________________

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