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	

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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