Today's Date_____

Child's Name_____DOB_____Sex_____

Family Background

Mother's Name_____DOB_____Occupation_____

Medical problems_____

Father's Name_____DOB_____Occupation_____

Medical problems_____

Names of other children	Age	Sex	Medical problems
1.			
2.			
3.			
4.			
5.			
6.			

Child's Medical History

Does or did your child have any delays in development? Were there any treatments for this?

Please Note the type of delay and treatments for it below.

Does your child have any allergies to medications or food, seasonal allergies, asthma, or eczema? Please describe below.

Has your child ever been hospitalized? If yes, please give details below of each admission as best you can (why they were admitted, how old they were, which hospital, how long they stayed).

Has your child had any surgery" if yes, please give details below (what surgery, how old they were, which hospital).

Has your child had any broken bones, or concussions? If yes, please give details below.

Does your child take any medications on a regular basis? If yes, please give details below.

Does your child seem to see and hear well?

REVIEW OF SYSTEMS- Child Brief

Name: _____ DOB: _____

****Please check only the symptoms your child currently has****

General
- ☐ Abnormal weight gain
- ☐ Abnormal weight loss
- ☐ Fatigue/weakness
- ☐ Frequent fevers
- ☐ Trouble sleeping

Skin
- ☐ Rash
- ☐ Lumps
- ☐ Itching
- ☐ Excessively dry skin
- ☐ Sun sensitivity
- ☐ Hair and nail changes

Head/Neck
- ☐ Frequent headaches
- ☐ Head injury
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Swollen glands
- ☐ Lumps

Eyes
- ☐ Eye redness
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Blurry or double vision
- ☐ Vision loss
- ☐ Wear glasses/contacts
- ☐ Other: _____

Ears
- ☐ Decreased hearing
- ☐ Frequent ear pain
- ☐ Ear drainage

Nose
- ☐ Constant nasal congestion
- ☐ Nasal discharge/drainage
- ☐ Frequent nosebleeds
- ☐ Sinus pain
- ☐ Decreased sense of smell

Throat/Mouth
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Constantly sore throat
- ☐ Hoarse voice
- ☐ Thrush
- ☐ Non-healing sores

Respiratory
- ☐ Frequent cough
- ☐ Coughing up phlegm
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Pain with breathing

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Chest tightness
- ☐ Palpitations (rapid heartbeat)
- ☐ Shortness of breath with exertion

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Frequent vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool

Urinary
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Wetting accidents
- ☐ Burning/painful urination
- ☐ Lower back pain
- ☐ Dark or bloody urine
- ☐ Decreased urine

Musculoskeletal
- ☐ Painful joints
- ☐ Frequent muscle aches
- ☐ Swollen joints
- ☐ Joint redness
- ☐ Back pain
- ☐ Trauma
- ☐ Difficulties walking

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Tingling/numbness
- ☐ Tremor (shaky hands)
- ☐ Tics
- ☐ Balance difficulty
- ☐ Gait abnormality
- ☐ Headache
- ☐ Loss of strength

Psychiatric/Behavioral
- ☐ Frequent temper tantrums
- ☐ Severe separation anxiety
- ☐ Sleep difficulties
- ☐ Behavioral problems
- ☐ School problems

Patient name: _____ DOB: _____

Family History

Condition: Relation to patient (mother, father, sibling, etc):

- ☐ ADHD _____
- ☐ Allergies or hay fever _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Arthritis _____
- ☐ Bleeding problems _____
- ☐ Birth defects/genetic defects _____
  -What kind of defect? _____
- ☐ Cancer _____
  -What kind of cancer? _____
- ☐ Blood clotting problems _____
- ☐ Depression _____
- ☐ Diabetes- type 1 _____
- ☐ Diabetes- type 2 _____
- ☐ Down syndrome _____
- ☐ Epilepsy/seizures _____
- ☐ Food allergies _____
  -What kind of food? _____
- ☐ Hearing loss _____
- ☐ Heart attack _____
- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ Hyperthyroidism ("high thyroid") _____
- ☐ Hypothyroidism ("low thyroid") _____
- ☐ Infertility _____
- ☐ Irregular heartbeat _____
- ☐ Intellectual disability/developmental delay: _____
- ☐ Kidney trouble (renal disease) _____
- ☐ Mood disorder or bipolar _____
- ☐ Neurofibromatosis _____
- ☐ Obesity _____
- ☐ Metabolic disease at birth _____
  -What kind of disease? _____
- ☐ Schizophrenia _____
- ☐ Smoking _____
- ☐ Stillbirth _____
- ☐ SIDS (sudden infant death) _____
- ☐ Stroke _____
- ☐ Vision loss _____
- ☐ Violence/domestic abuse _____
- ☐ Alcohol abuse _____
- ☐ Drug abuse _____