Pediatric Form

Child's Name: _____
Date: _____ Age: _____ Sex: _____

Symptoms
(mark C for current and P for past symptoms)

_____Hives
_____Eczema
_____Chronic Rash
_____Hair Loss
_____Excessive Fatigue
_____Bed Wetting
_____Sore Throats
_____Frequent Colds
_____Canker Sores
_____Burning Urination
_____Cries Easily
_____Sleep Problems
_____Nightmares
_____Night Sweats
_____Walks in Sleep

_____Talks in Sleep
_____Bruises Easily
_____Dizzy Spells
_____Cough
_____Wheezing
_____Anemia
_____High Fevers
_____Blood in Urine
_____Stomach Aches
_____Constipation
_____Diarrhea
_____Gas
_____Change in Appetite
_____No Appetite

_____Vomiting Spells
_____Bleeding Gums
_____Jaundice
_____Nosebleeds
_____Nervous
_____Sensitive to Light
_____Bad Breath
_____Body Odor
_____Motion Sickness
_____Freq. Headaches
_____Joint Pains
_____Flat Feet
_____Hearing Loss
_____Heart Murmur

Medical History

- ☐ Frequent Colds
- ☐ Allergies
- ☐ Ear Infections
- ☐ Tonsillitis
- ☐ Rheumatic Fever
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Pneumonia

Other:_____
_____
_____

Medications

- ☐ Aspirin
- ☐ Tylenol
- ☐ Decongestant
- ☐ Antibiotics
- ☐ Anti-Histamine
- ☐ Ibuprofen

Other:_____
_____
_____
_____

Nutritional Supplements:

_____

_____

Drug Allergies:

_____

Immunizations

- ☐ Measles
- ☐ Polio
- ☐ Small Pox
- ☐ Influenza
- ☐ Mumps
- ☐ Tetanus
- ☐ Hepatitis
- ☐ Diphtheria

Any Reactions:

_____

_____

_____

Mother's Health During Pregnancy:
(check all that apply)

- ☐ Bleeding
- ☐ Nausea
- ☐ Physical or Emotional Trauma
- ☐ Medications
- ☐ Illnesses
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cigarettes, Alcohol, Drugs
- ☐ Thyroid Problems

Term: _____Full _____Premature _____Late

Birth Weight:_____

Has your child had any of the following problems?

- ☐ Jaundice
- ☐ "Blue Baby"
- ☐ Colic
- ☐ Diarrhea