Patient Name:_____ Date:_____

Current Medications

Please list all medications you are taking at this time, include vitamins, topicals, injections, supplements & herbals or provide a complete list (use back if needed)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Why do you take this medication?
1			
2			
3			
4			
5			
6			
7			
8			

PHARMACY_____

Allergies-*Please list all medications and environmental agents you are allergic to. Please include what type of reaction you have (hives, nausea, breathing problems, etc.) and severity.*

_____
_____
_____
_____

Past Medical History- *Please include all medical problems such as diabetes, hypertension, etc.*

_____
_____
_____
_____

Past Surgical History- *Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc. Include year completed*

_____
_____
_____
_____

Family History-*Please list all major medical conditions.*

Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Specify grandmother as GM grandfather as GF
Maternal Grandparent_____
Paternal Grandparent _____
Other_____

Patient Name:_____ Date:_____

Social history:

Passive Smoke exposure: yes/ no

Child Lives with (circle all that apply) : Mom Dad Step parent sibling grandparent Other_____

Number of Siblings:_____

Does the child participate in any sports or extracurricular activities: Yes/ No

Type_____

Length: Seasonal/ year long

If applicable, how many times per week?_____

Do you own any animals or pets? _____

Primary care physician or pediatrician_____

Specialists_____

Patient Name:_____ Date:_____

Review of Systems Child (symptoms within the last 7 days

Constitution

Activity Change	**YES**	**NO**
Fever	**YES**	**NO**
Unexpected Weight Change	**YES**	**NO**

Ears/Nose/Throat

Congestion	**YES**	**NO**
Hearing loss	**YES**	**NO**
Nosebleeds	**YES**	**NO**
Sore Throat	**YES**	**NO**

Eyes

Visual Disturbance	**YES**	**NO**

Respiratory

Cough	**YES**	**NO**
Shortness of Breath	**YES**	**NO**
Wheezing	**YES**	**NO**

Gastroenterology

Abdominal pain	**YES**	**NO**
Constipation	**YES**	**NO**
Vomiting	**YES**	**NO**

Endocrine

Cold Intolerance	**YES**	**NO**
Heat Intolerance	**YES**	**NO**

Urinary

Difficulty urinating	**YES**	**NO**
Frequent Urination	**YES**	**NO**
Urgency	**YES**	**NO**

Musculoskeletal

Joint pain	**YES**	**NO**
Muscle pain	**YES**	**NO**

Skin

Color Change	**YES**	**NO**
Rash	**YES**	**NO**
Wound	**YES**	**NO**

Immune

Immunocompromised	**YES**	**NO**

Hematologic

Bruises easily	**YES**	**NO**

Neurological

Headaches	**YES**	**NO**
Seizure	**YES**	**NO**

Behavioral

Behavior problem	**YES**	**NO**
Hyperactive	**YES**	**NO**
Nervous/anxious	**YES**	**NO**
Suicidal ideas	**YES**	**NO**