Pediatric Patient Health Care Survey

Name	DOB	Date	Accompanied to Visit by

☐ Mom ☐ Dad
☐ Grandparent
☐ Caregiver

Parent First Name	2nd Parent First Name	Other Accompanying Adult's First Name

Please describe the reason for your child's visit today:

What treatments or testing have been tried for this problem? Please list over the counter as well as prescription medications. Please also include any allergy testing, CAT scans, MRI, Bloodwork, hearing tests or sleep study that your child may have had.

Has your child seen any other providers to evaluate this problem?

Did you bring any medical records from other physicians with you today?

Please Mark All of Your Child's Current Symptoms:

Allergy
- ☐ Environmental Allergies
- ☐ Frequent Itching
- ☐ Headache
- ☐ Rash
- ☐ Itchy Eyes
- ☐ Immunosuppression

Sleep
- ☐ Snoring
- ☐ Restless sleep/ awakenings
- ☐ Difficulty Falling Asleep
- ☐ Excessive Daytime Sleepiness
- ☐ Breathholding during sleep

Ears & Balance
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Ear Pressure
- ☐ Excessive Ear Wax
- ☐ Hearing Loss
- ☐ Loss of Balance
- ☐ Noise Exposure
- ☐ Ringing in the Ears
- ☐ Vertigo

Nose & Sinus
- ☐ Can't Breathe Through
- ☐ Diminished Smell

Nose & Sinus
- ☐ Facial Pain
- ☐ Nasal Bleeding
- ☐ Nasal Congestion
- ☐ Nasal Discharge
- ☐ Postnasal Drip
- ☐ Shortness of Breath
- ☐ Sneezing
- ☐ Sinus Problems

Throat & Neck
- ☐ Cough
- ☐ Coughing Blood
- ☐ Difficulty Swallowing
- ☐ Drooling

Throat & Neck
- ☐ Hoarseness
- ☐ Lump in Throat
- ☐ Lymph Node Swelling
- ☐ Mouth Sores
- ☐ Neck Mass
- ☐ Neck Pain
- ☐ Pain with Swallowing
- ☐ Sore Throat

Other
- ☐ Abnormal Bleeding
- ☐ Chest Pain
- ☐ Changes in Vision
- ☐ Chills

Other
- ☐ Depression
- ☐ Fever
- ☐ Mood Swings
- ☐ Nausea
- ☐ Urinary Tract Infections
- ☐ Vomiting
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Crying or Irritable
- ☐ Fussy
- ☐ Slow Weight Gain
- ☐ Failure to Thrive
- ☐ Difficulty Nursing
- ☐ Respiratory Distres

Please list any other symptoms your child may be having:

Family History — **Please check all that apply.**

	Mother	Father	Sister	Brother	Son	Daughter
Alive and Doing Well	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯
Hearing Loss	◯	◯	◯	◯	◯	◯
Environmental Allergies	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯
Thyroid Disease	◯	◯	◯	◯	◯	◯
Bleeding Disorder	◯	◯	◯	◯	◯	◯
Cancer (List Type)						
Cause of Death						

Other Family History

Past Medical & Surgical History

Patient Name	Date of Birth

Allergy/Immunology

☐ None, if checked skip to next section

Allergies (Not Related to Medications)
If Yes, Please Mark/Describe ☐ Yes ☐ No

◯ Adhesive Tape ◯ Bees/Insects ◯ Eggs ◯ Environmental
◯ Food ◯ Latex ◯ Milk ◯ Peanuts
◯ Seafood ◯ Seasonal

Others:

Reaction to Anesthesia? ☐ Yes ☐ No
◯ General ◯ Local

If Yes, describe

Reaction to X-Ray Dye? ☐ Yes ☐ No
If Yes, describe

Atopic Eczema	☐ Yes	☐ No
Contact Dermatitis	☐ Yes	☐ No
Eczema/Psoriasis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Immunizations - Up to Date?	☐ Yes	☐ No
Juvenile Rheumatoid Arthritis	☐ Yes	☐ No

Birth and Developmental History

Complete this Section for Patients Age 1 - 3

Anemia	☐ Yes	☐ No
Developmental Milestones		
Turns to Sound (4 Months)	☐ Yes	☐ No
Responds to Name (6 Months)	☐ Yes	☐ No
Mama/Dada (9 Months)	☐ Yes	☐ No
Walk Alone (12 month)	☐ Yes	☐ No
Two Word Sentence - (2 Yrs)	☐ Yes	☐ No
Full Term Healthy Infant	☐ Yes	☐ No

If no, describe

Infections at Birth ☐ Yes ☐ No

If yes, describe

ICU Admission ☐ Yes ☐ No

NICU Stay ☐ Yes ☐ No

If yes to ICU or NICU describe

Passed Hospital Hearing Screen ☐ Yes ☐ No

Other Birth History

Cardiovascular

☐ None If checked skip to next section.

Cardiac Arrythmia	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
/Mitral Valve Prolapse	☐ Yes	☐ No
If Yes, Do you require antibiotic prophylaxis for procedures?	☐ Yes	☐ No
Patent Ductus Arteriosus (PDA)	☐ Yes	☐ No

Genetic

☐ None If checked skip to next section.

Cystic Fibrosis	☐ Yes	☐ No
Down's Syndrome	☐ Yes	☐ No
Turner's Syndrome	☐ Yes	☐ No

Dermatologic

Birth Mark	☐ Yes	☐ No
Hives/Urticaria	☐ Yes	☐ No

Ear, Nose & Throat

Adenoidectomy	☐ Yes	☐ No
Ear Infections ☐ Chronic ☐ Recurrent	☐ Yes	☐ No
Ear Wax, Recurrent	☐ Yes	☐ No
Ear Tubes	☐ Yes	☐ No
Frenulectomy	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Nasal Fracture List	☐ Yes	☐ No
Other Ear Surgery	☐ Yes	☐ No
Perforated Ear Drum	☐ Yes	☐ No
Swimmer's Ear	☐ Yes	☐ No
Tonsil Enlargement	☐ Yes	☐ No
Tonsillectomy	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Upper Respiratory Infections , Frequent	☐ Yes	☐ No
Sinusitis	☐ Yes	☐ No
Vocal Cord Nodules	☐ Yes	☐ No

Gastrointestinal

☐ None If checked skip to next section.

Appendectomy	☐ Yes	☐ No
Food Sensivity	☐ Yes	☐ No
Chronic Constipation	☐ Yes	☐ No
Formula Intolerance	☐ Yes	☐ No
GERD	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Lactose Intolerance	☐ Yes	☐ No
Heartburn/Reflux	☐ Yes	☐ No
Obesity	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Stomach Ulcer	☐ Yes	☐ No

Hematology

☐ None If checked skip to next section.

Anemia	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No

Infectious

Croup	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Lyme Disease	☐ Yes	☐ No
Methicillin-Resistant Staphylococcus Aureaus (MRSA)	☐ Yes	☐ No
Pertussis	☐ Yes	☐ No
Respiratory Synctial Virus (RSV)	☐ Yes	☐ No

Metabolic/Endocrine

Diabetes Mellitus Type I	☐ Yes	☐ No
Obesity	☐ Yes	☐ No

Patient Name	Date of Birth

Past Medical History (continued)

Neurology

ADD/ADHD	☐ Yes	☐ No
Autism/Autism Spectrum Disorder	☐ Yes	☐ No
Developmental Delay	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Seizure Disorder/Epilepsy	☐ Yes	☐ No
Scoliosis	☐ Yes	☐ No
Tourette's Syndrome	☐ Yes	☐ No

Pulmonary

Asthma	☐ Yes	☐ No
Aspiration Pneumonia	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Laryngospasm	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No

Misc

Tooth Decay	☐ Yes	☐ No

Past Birth or Medical History Not Listed Above (Use back of page to continue if needed)

Immunization Dates

Please fill in the most recent date for applicable vaccinations. or attach child's immunization record.

Influenza	Pneumococccal	MMR	DTaP	Varicella (VAR)	Tdap	Hep B

Home Environment & Habits

Is there secondhand smoke exposure at home? ☐ Yes ☐ No

Are there animals in the home? ☐ Yes ☐ No If Yes, ◯ Dog ◯ Cat ◯ Bird

Other Pets

Home Heating and Cooling:

◯ Gas ◯ Hot Air ◯ Electric ◯ Wood

◯ Oil ◯ Propane ◯ Solar

Other Heat

Air Conditioning at Home? ☐ Yes ☐ No If Yes, ◯ Central Air ◯ Room

Does your child sleep well on a regular basis? ☐ Yes ☐ No If no, describe

Does your child drink beverages containing caffeine? ☐ Yes ☐ No If Yes, how much?

Does your child drink water on a daily basis? ☐ Yes ☐ No Amt Per Day

Does your child attend day care? ☐ Yes ☐ No If Yes, how many days per week?

Pre School Age Children Only

Medications & Allergies

Is your child currently taking any medications? ☐ Yes ☐ No

If Yes, Please List Current Medications Below (over the counter and prescription) Use back of page for additional room.

Does your child have any medication allergies? ☐ Yes ☐ No

If Yes, Please List all Known Allergies below:

Local Pharmacy		Mail Order Pharmacy	
Local Pharmacy Name	Local Pharmacy Phone	Mail Order Pharmacy Name	Mail Order Pharmacy Phone

Parent or Guardian's Signature: _____ **Date:** _____