Neelam Kharod Sell, M.D.
Developmental–Behavioral Pediatrics

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Developmental-Behavioral Pediatrics Interim Medical History

Date of Last Visit: _____ Name: _____

Please indicate whether your child has any of the following problems currently or since last seen. If yes, describe.

Headaches	NO	YES _____
Stomachaches	NO	YES _____
Chest pain	NO	YES _____
Other Pain	NO	YES _____
Poor appetite	NO	YES _____
Breathing Problems	NO	YES _____
Passing Out/Dizziness	NO	YES _____
Seizure	NO	YES _____
Aggressive behavior	NO	YES _____
Injuring himself or herself	NO	YES _____
Repetitive Behaviors/Habits	NO	YES _____
Tics	NO	YES _____
Worries or Fears	NO	YES _____
Sleep Problems	NO	YES _____
Constipation	NO	YES _____
Wetting pants or bed	NO	YES _____
Soiling pants or bed	NO	YES _____

Do you have concerns about your child's safety? NO YES _____

Please list any medications, supplements, or vitamins that your child is taking:
1._____
2. _____
3. _____

Does your child have allergies to:

Drugs	NO	YES _____
Foods	NO	YES _____
Latex	NO	YES _____
Contact	NO	YES _____
Contrast give for x-ray studies	NO	YES _____
Blood products	NO	YES _____

Are there other concerns or events since the last visit that you think we should know about?
_____

_____