



Are there any problems that concern you about your child right now? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any allergies to food or medication? \_\_\_\_ If yes, please list and explain reaction. \_\_\_\_\_  
 \_\_\_\_\_

List medications and dosages child is presently taking, including vitamins and supplements: \_\_\_\_\_  
 \_\_\_\_\_

**Review of Symptoms:** Indicate which of the following conditions or problems your child has *recently* had:

<input type="checkbox"/> Eye problems	<input type="checkbox"/> Acne	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Eczema	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Rashes	<input type="checkbox"/> Constipation
<input type="checkbox"/> Frequent ear infections		
<input type="checkbox"/> Difficulty hearing	<input type="checkbox"/> Kidney/Bladder infection	<input type="checkbox"/> Headaches
<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Seizures
<input type="checkbox"/> Frequent sore throats		<input type="checkbox"/> Learning difficulties
	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Behavioral problems
<input type="checkbox"/> Asthma or bronchitis	<input type="checkbox"/> Sexually active	<input type="checkbox"/> Weight issues

**Social History:**

What does child do in spare time? \_\_\_\_\_

How much times does child spend watching TV, play video games, or use computer \_\_\_\_\_

How is he/she doing in school? \_\_\_\_\_

Does he/she have good friends? \_\_\_\_\_

Indicate any financial, interpersonal, or family problems you are worried about. \_\_\_\_\_  
 \_\_\_\_\_

**Family History:** Indicate conditions which close relatives (parents, siblings, & grandparents) have:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Migraine	<input type="checkbox"/> Obesity
<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Cholesterol
	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eczema	<input type="checkbox"/> Psychiatric disorders	Other:
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	

\_\_\_\_\_  
 Date Completed

\_\_\_\_\_  
 Reviewed by: (MD, DO, NP, PA)