Child New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Parent or Guardian's Name: _____

Chief Complaint or Concern:

_____

_____

_____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Does your child have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Has your child ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

ALLERGY HISTORY

❑None Known ❑ Yes, to: 1._____ 3._____

2._____ 4._____

Pets: ❑ No ❑ Yes How many? _____ What type of pet? _____

Do any pets sleep in your child's bedroom? ❑ No ❑ Yes

Which pets? _____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

❑ High blood pressure/hypertension	❑ Diabetes	❑ Chronic insomnia
❑ Heart disease	❑ Overweight/obesity	❑ Restless legs syndrome
❑ Stroke	❑ Snoring	❑ Multiple sclerosis
❑ Congestive heart failure	❑ Sleep apnea	❑ Sleep walking
❑ Depression	❑ Anxiety	

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite:	❑ Yes ❑ No
Fever:	❑ Yes ❑ No
Fatigue:	❑ Yes ❑ No
Weight Gain:	❑ Yes ❑ No
Weight Loss:	❑ Yes ❑ No

Respiratory:

Cough:	❑ Yes ❑ No
Asthma:	❑ Yes ❑ No
Wheezing:	❑ Yes ❑ No
Poor Exercise Tolerance:	❑ Yes ❑ No

REVIEW OF SYMPTOMS

Gastrointestinal:

Heartburn/Indigestion: ❑ Yes ❑ No

Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No

Nausea/Vomiting: ❑ Yes ❑ No

Jaundice: ❑ Yes ❑ No

Abdominal Pain ❑ Yes ❑ No

Allergy/Immunology:

Nasal allergies/Hay fever/

Nasal Congestion**:** ❑ Yes ❑ No

Sneezing**:** ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Itchy Eyes or Nose: ❑ Yes ❑ No

Hives: ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss : ❑ Yes ❑ No

Genitourinary:

Frequent Urination ❑ Yes ❑ No

Difficulty Urinating: ❑ Yes ❑ No

Blood in Urine: ❑ Yes ❑ No

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No

Muscle Pain: ❑ Yes ❑ No

Red or Swollen Joints: ❑ Yes ❑ No

Temporomandibular Joint

(TMJ) pain/jaw discomfort: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

Tubes in Ears: ❑ Yes ❑ No

REVIEW OF SYMPTOMS

Cardiac:

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Hypertension/High Blood Pressure ❑ Yes ❑No

Skin:

Unusual Moles: ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

Endocrine:

Heat Intolerance ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ Yes ❑ No

Neurologic:

Weakness: ❑ Yes ❑ No

Seizures: ❑ Yes ❑ No

Involuntary Tongue Biting: ❑ Yes ❑ No

Passing Out: ❑ Yes ❑ No

Dizziness: ❑ Yes ❑ No

Headaches: ❑ Yes ❑ No

Numbness: ❑ Yes ❑ No

Psychiatric:

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Was your child breast fed? ❑ Yes ❑ No

If your child was breast fed – for how long? _____

Was your child ❑ Full Term ❑ Premature

If Premature – at how many weeks was your child delivered? _____

Guardian Signature _____ Relationship _____ Date_____

Dentist Signature _____ Date _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION