generationcare
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# PEDIATRIC HISTORY FORM

In order for us to fully address all aspects of your problem, the following information is needed. Please complete the form below as completely as you can. Feel free to ask for assistance. Thank you!

## BACKGROUND INFORMATION FOR THE CHILD

Today's Date_____

Name:_____ Birth Date:_____ Age:_____ Sex:_____

Diagnosis:_____

What are the present concerns for your child?_____

_____

_____

Who are your child's doctors?_____

## FAMILY INFORMATION

Father's name:_____ Mother's name:_____

Guardian's name:_____ Relationship:_____

## CHILD'S MEDICAL HISTORY

Immunization up to date? Y or N Has your child received a Flu vaccine this year? Y or N

Please indicate if your child has had any of the following illnesses/infections, also indicate the frequency in the last 6 months:

Chicken Pox_____ Strep Throat:_____ Mumps:_____

R.S.V.:_____ Scarlet Fever:_____ Pneumonia:_____

Tuberculosis:_____ HIV:_____ Ear Infections:_____

Sinus Infections:_____ Nasal Drainage:_____ Bronchitis:_____

Tonsillitis:_____ Congestion:_____ Asthma:_____

Diabetes:_____ Vomiting:_____ Diarrhea:_____

Constipation:_____ Gastrointestinal Problems:_____

Shunt Malfunction:_____

Fevers below 100°:_____ Fevers above 100°:_____

Has your child had a cardiac disorder (describe):_____

_____

Has your child had a respiratory disorder (describe):_____

_____

Has your child experienced seizures? Y or N Age of onset:_____ Seizure type:_____