REQUESTING/PRIMARY DOCTOR: _____ Patient Name: _____

Reason for Consultation: _____ Date of Birth: _____

PEDIATRIC MEDICAL INFORMATION

BIRTH HISTORY

__ Full Term (40 weeks)
__ Vaginal or Cesarean Section (circle one)

__ Preterm (less than 40 weeks) # of weeks at delivery ____
__ Vaginal or Cesarean Section (circle one)
NICU stay? Yes or No (circle one)
Duration of NICU stay: _____ for what reason: _____

CHRONIC MEDICAL PROBLEMS

__ **NONE**

__ Heart Murmur
__ Asthma/Reactive airway disease
__ Gastroesophageal reflux
__ Febrile seizure
__ Urinary tract infection
__ Recurrent?
__ ADHD
__ Allergies
__ Birth defect
__ Bleeding problems
__ Cancer
__ Cerebral palsy
__ Depression
__ Down Syndrome
__ Epilepsy/Seizures
__ Sickle cell anemia
__ Other (Please list below):

SURGERIES AND HOSPITALIZATIONS (WITH AGE OR DATE): (Please list) __ NONE

If you child has had surgery before, did they have any problems with the anesthesia? Yes or No (Circle one)
If yes, please explain:

CURRENT MEDICATIONS __ NONE

(Please list on the attached form)

ALLERGIES __ NONE KNOWN

__ Medications (Please list):

__ Food (Please list):
__ Latex

SMOKING (If the child is 13 years old or greater)

Has the patient ever smoked: __ Yes, currently __ No
__ Yes, in the past

SOCIAL HISTORY

Who does the child live with?
(Please check all that apply)
__ Mom __ Dad
__ Step-mom __ Step-dad
__ Sister(s) How many? ___
__ Brother(s) How many? ___
__ Other: _____

Is the child adopted or in foster care? Yes or No (circle one)
If yes, please bring custody paperwork to the visit.

Are there any pets in the house? Yes or No (circle one)
Does anyone who cares for the child smoke?
Yes or No (circle one)

FAMILY HISTORY (Does anyone in your FAMILY have any of the following):

Severe reactions to anesthesia (ie: Malignant Hyperthermia)				Yes	No
Bleeding Problems	Yes	No	Bedwetting	Yes	No
Renal/Kidney failure	Yes	No	Recurrent UTI's	Yes	No
Kidney transplant	Yes	No	Hypospadias	Yes	No
Hypertension	Yes	No	Vesicoureteral reflux	Yes	No
Kidney stones	Yes	No			

Any other diagnosis in the family (parents, siblings, aunts/uncles, grandparents)? Please list:

Reviewed by (Doctor/NP): _____ Date: _____