PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

Child's Name: ___________________________________ Date: ____________________

Age: __________ Date of Birth: __________________

Sex: F___________ M _____________

For Office use only:

SYMPTOMS

(mark C for current and P for past symptoms)

_____ Hives	____ Talks in sleep	____Vomiting spells
_____ Eczema	____ Bruises easily	____ Bleeding gums
_____ Chronic rash	____ Dizzy spells	____ Jaundice
_____ Hair loss	____ Cough	____ Nosebleeds
_____ Excessive fatigue	____ Wheezing	____ Nervous
_____ Bed wetting	____ Anemia	____ Sensitive to light
_____ Sore throats	____ High fevers	____ Bad breath
_____ Frequent colds	____ Blood in urine	____ Body Odour
_____ Canker sores	____ Stomach aches	____ Motion sickness
_____ Burning urination	____ Constipation	____ Freq. Headaches
_____ Cries easily	____ Diarrhea	____ Joint pains
_____ Sleep problems	____ Gas	____ Flat feet
_____ Nightmares	____ Change in appetite	____ Hearing loss
_____ Night sweats	____ No appetite	____ Heart murmur
_____ Walks in sleep		

MEDICAL HISTORY

Frequent colds	Measles
Allergies	Mumps
Ear Infections	Rubella
Tonsillitis	Scarlet Fever
Rheumatic Fever	Pneumonia
Chicken Pox	

Other (please list)

____

____

____

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MEDICATIONS

Aspirin	Antibiotics
Tylenol	Anti-Histamine
Decongestant	Ibuprofen

Others (please list)

____

____

Nutritional supplements (please list):

____

____

Do you know of any drug allergies?

____

IMMUNIZATIONS

Measles	Mumps
Polio	Tetanus
Small pox	Hepatitis
Influenza	Diphtheria

Any reactions?

____

____

MOTHER'S HEALTH DURING PREGNANCY:
(check all that apply)

Bleeding	Diabetes
Nausea	Hypertension
Physical or Emotional Trauma	Thyroid Problems
Medications	Illnesses
Cigarettes, Alcohol, Drug Consumption	

TERM:

Full ____ Premature ____ Late ____

Weight at birth: __________________________

Has your child had any of the following problems

Jaundice	Colic
"Blue Baby"	Diarrhea