Pt Name: ______________________________ **Date:** ______________________________

Parent/Guardians: Please help us provide the best possible care for your child by filling out this sheet as best you can.

Allergies (medications/food/other):____

Immunizations: ☐ Up-to-date ☐ Not Up-to-date ☐ Unsure

Regular physician: ______________________ Phone: ______________________

Current medication and dose:____

What illnesses has your child been exposed to recently? __________________ ☐ None

Other common infections? ______________________________ ☐ None

Major illness/Conditions: ______________________________ ☐ None

Previous surgeries: ______________________________ ☐ None

Overnight hospital stays (give age and reason):______________________________

____ ☐ None

Who are the patients' parents main caretakers? ☐ Mother ☐ Father ☐ Self ☐ Other

Who is legal guardian?____________________Who else lives at home?____________________

Do any of the following conditions run in the family?	**Yes**	**No**	**What relative?**
Seizures (epilepsy)---	☐	☐	____________
Asthma--	☐	☐	____________
Heart Problems--	☐	☐	____________
Migraines---	☐	☐	____________
Other serious childhood illness--------------------------------	☐	☐	____________
Deaths in childhood---	☐	☐	____________
Bleeding Disorders--	☐	☐	____________
Problems with anesthesia--------------------------------------	☐	☐	____________

Does the patient have any of the following symptoms? *(check all that apply)*

Shortness of breath---------------☐

Chest pain------------------------☐

Abdomen pain---------------------☐

Diarrhea--------------------------☐

Constipation----------------------☐

Seizure---------------------------☐

Vomiting--------------------------☐

Fever-----------------------------☐

Depression--------------------------☐

Painful urination--------------------☐

Increased drinking------------------☐

Decreased appetite------------------☐

Cough--------------------------------☐

Rash---------------------------------☐

Other--------------------------------☐