

PEDIATRIC ASSOCIATES OF NORTH TEXAS

PATIENT DATA

Patient's Name _____ Date of Birth _____

Family History: Is there any history of the following illnesses in your family? (Go back to child's great grandparents)

| | YES | NO | DETAILS |
|--|-------|-------|---------|
| 1. Allergies (asthma, hay fever, eczema) | _____ | _____ | _____ |
| 2. Birth Defects | _____ | _____ | _____ |
| 3. Bleeding Disorders (hemophilia, etc.) | _____ | _____ | _____ |
| 4. Eye Problems (squint, cross-eyed, etc.) | _____ | _____ | _____ |
| 5. Ear Problems (deafness, infections) | _____ | _____ | _____ |
| 6. Diabetes | _____ | _____ | _____ |
| 7. Heart Trouble | _____ | _____ | _____ |
| 8. Kidney Disease | _____ | _____ | _____ |
| 9. Mental Retardation | _____ | _____ | _____ |
| 10. High Blood Pressure | _____ | _____ | _____ |
| 11. Obesity | _____ | _____ | _____ |

Name any other illnesses that seem to run through either side of your family _____

Hospitalization:

Age _____ Problem _____

Birth History:

Term _____ Premature _____ Weight _____
 Any problems? _____

Check if more _____

Allergies: Does your child have any allergies? _____ Drug _____ Food _____

Medications: List names of drugs your child has taken over a long period _____

Systematic Review: Answer YES or NO if your child has ever had the following:

| | YES | NO | | YES | NO |
|------------------------------------|-------|-------|----------------------------|-------|-------|
| 1. Head: | | | 9. Abdomen: | | |
| Skull fracture | _____ | _____ | Yellow jaundice | _____ | _____ |
| Concussion / loss of consciousness | _____ | _____ | Bloody bowel movements | _____ | _____ |
| 2. Eyes: | | | Frequent abdominal pain | _____ | _____ |
| Difficulty seeing | _____ | _____ | Frequent diarrhea | _____ | _____ |
| Eyes crossing | _____ | _____ | 10. Urinary Tract: | | |
| 3. Ears: | | | Pain, frequency, or | | |
| Frequent infection | _____ | _____ | burning on urination | _____ | _____ |
| Hearing loss | _____ | _____ | Repeated infections | _____ | _____ |
| Placement of ear tubes | _____ | _____ | Blood in urine | _____ | _____ |
| 4. Nose: | | | Swelling of eyes/ankles | _____ | _____ |
| Frequent sneezing/rubbing | _____ | _____ | 11. Blood: | | |
| 5. Throat: | | | Anemia | _____ | _____ |
| Frequent strep throat | _____ | _____ | Excessive bruising | _____ | _____ |
| 6. Neck: | | | 12. Extremities: | | |
| Enlarged glands | _____ | _____ | Weakness, limp, paralysis | _____ | _____ |
| Enlarged thyroid | _____ | _____ | Joint swelling | _____ | _____ |
| 7. Heart: | | | 13. Neurological: | | |
| Heart murmur ever been heard | _____ | _____ | Frequent, severe headaches | _____ | _____ |
| Blue spells | _____ | _____ | Convulsions or fits | _____ | _____ |
| Irregular heart beat | _____ | _____ | Fainting or black-outs | _____ | _____ |
| 8. Lungs: | | | | | |
| Pneumonia | _____ | _____ | | | |
| Tuberculosis | _____ | _____ | | | |
| Asthma | _____ | _____ | | | |
| Wheezing | _____ | _____ | | | |