Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Pediatric History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

CAFFEINE

On a **typical day**, how many cups of caffeinated **coffee**, **tea** and **cola / soda** does the patient drink?

○ 0 ○ 1-2 ○ 3-4 ○ 5 or more

TOBACCO

Please describe the patient's cigarette smoking.
(If the patient does not smoke now, but has smoked more than 5 packs in a lifetime, mark "previous".)

○ current (every day) ○ current (some days) ○ previous ○ never

Is the patient exposed to passive (secondhand) smoke? ○ yes, outdoors only ○ yes ○ no

SURGICAL HISTORY

Please mark all surgeries the patient has had:

○ **PATIENT HAS HAD NO SURGERIES**

○ Adenoidectomy (Adenoids) What year: _____

○ Sinus Surgery What year: _____

○ Tonsillectomy (Tonsils) What year: _____

○ Other Surgeries (please specify type and approximate date): _____

_____

_____

_____

_____

MEDICAL HISTORY

Please mark all symptoms and conditions the patient has ever experienced:

○ ADHD	○ Down Syndrome	○ Learning Difficulties	○ Thyroid Disease
○ Acid Reflux / Heartburn	○ Headaches	○ Obesity	○ Other (please specify):
○ Asthma	○ High Blood Pressure	○ Seizures / Epilepsy	_____
○ Diabetes	○ High Cholesterol	○ Sickle Cell / Anemia Trait	○ **NONE OF THE ABOVE**

FAMILY HISTORY

Please choose all symptoms / conditions the patient's family members have experienced:

Father	Mother	Brother	Sister	Grandparent	Other	Unaware of any family members with this	
○	○	○	○	○	○	○	Narcolepsy
○	○	○	○	○	○	○	Restless Leg Syndrome
○	○	○	○	○	○	○	Heavy Snoring
○	○	○	○	○	○	○	Sleepwalking

CURRENT SYMPTOMS

Please mark only the symptoms the patient is **CURRENTLY** experiencing.
Mark all that apply. If no symptoms in a category, please mark '**NONE**".

General	○ fatigue	○ weight gain	○ **NONE**
Ear / Nose / Throat	○ allergies	○ nasal congestion	○ **NONE**
Cardiovascular	○ edema	○ palpitations / fast heartbeat	○ **NONE**
Respiratory	○ chronic cough	○ shortness of breath	○ **NONE**
Gastrointestinal	○ constipation	○ diarrhea	○ **NONE**
Genital / Urinary	○ bedwetting	○ frequent urination during the day	○ **NONE**
Musculoskeletal	○ muscle pain	○ joint pain	○ **NONE**
Neurologic	○ dizziness	○ difficulty with concentration	○ **NONE**
Psychiatric	○ depression	○ anxiety	○ **NONE**
Endocrine	○ intolerance to cold	○ intolerance to heat	○ **NONE**