



Patient Name: \_\_\_\_\_

Today's date: \_\_\_\_\_

**PEDIATRIC MEDICAL HISTORY:** Please check all that apply. Please apply dates where applicable.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dental cares /<br>sealants current            | <input type="checkbox"/> Jaundice                        | <input type="checkbox"/> Short frenulum                      |
| <input type="checkbox"/> ADHD  | <input type="checkbox"/> Kidney or bladder<br>problems   | <input type="checkbox"/> Sickle cell anemia or<br>trait      |
| <input type="checkbox"/> Allergies                                     | <input type="checkbox"/> Learning problems               | <input type="checkbox"/> Strabismus                          |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Meningitis                      | <input type="checkbox"/> Strep throat                        |
| <input type="checkbox"/> Arthritis                                     | <input type="checkbox"/> Neurologic problems             | <input type="checkbox"/> Tension or anxiety                  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Orthopedic problems             | <input type="checkbox"/> Trauma                              |
| <input type="checkbox"/> Atopic dermatitis /<br>eczema                 | <input type="checkbox"/> OT/PT/Speech<br>Therapy         | <input type="checkbox"/> Urinary tract infections            |
| <input type="checkbox"/> Autism  | <input type="checkbox"/> Developmental<br>problems _____ | <input type="checkbox"/> Vision problems                     |
| <input type="checkbox"/> Behavior problems                             | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Wheezing/Reactive<br>airway disease |
| <input type="checkbox"/> Birth defects / genetic<br>disorders<br>_____ | <input type="checkbox"/> Emotional problems              | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Bladder infection<br>(recurrent)              | <input type="checkbox"/> Frequent ear<br>infections      | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Bronchitis                                    | <input type="checkbox"/> Gastroesophageal<br>reflux      |  |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Hearing problems                |  |
| <input type="checkbox"/> Chickenpox                                    | <input type="checkbox"/> Heart murmur                    |  |
| <input type="checkbox"/> Congenital heart<br>disease                   | <input type="checkbox"/> Overweight                      |  |
| <input type="checkbox"/> Constipation                                  | <input type="checkbox"/> Picky eater                     |  |
| <input type="checkbox"/> Cystic fibrosis                               | <input type="checkbox"/> Pneumonia                       |  |
| <input type="checkbox"/> Depression                                    | <input type="checkbox"/> Prematurity _____               |  |
| <input type="checkbox"/> Immunization reaction                         | <input type="checkbox"/> Scoliosis                       |  |
| <input type="checkbox"/> Immunization refusal /<br>delay               | <input type="checkbox"/> Seizures/epilepsy               |  |
|  | <input type="checkbox"/> Sensory Integration<br>disorder |  |